

THE MEDICAL NEWS.

A WEEKLY JOURNAL OF MEDICAL SCIENCE

VOL. LXXVI.

NEW YORK, SATURDAY, MAY 19, 1900.

No. 20.

ORIGINAL ARTICLES.

THE STATUS OF GYNECOLOGY IN 1876 AND 1900.¹

By ALEX. J. C. SKENE, M.D.,
OF NEW YORK.

THE conception of modern gynecology began about seventy-five years ago when obstetricians discovered that woman was more than a mechanism for reproduction, and surgeons became fully aware that they had much to learn regarding her diseases and their treatment. This realization of the unknown awakened interest and gave a new impetus to the evolution of gynecology. Slowly, almost imperceptibly, learning advanced in this branch until thirty-five years ago, when, stimulated by the ever brightening light of modern medicine, the development and growth in this field became progressive to an amazing degree.

Twenty-five years ago the knowledge of this branch of medicine had grown sufficiently great to entitle gynecologists to a special position in the profession. At this time gynecology may be said to have graduated with honors and to have taken a well-merited position among the grand divisions of the profession. This graduation—so far as this country is concerned—took place at the advent of the American Gynecological Society, an occasion which lingers in the memory now as an inspiration and a benediction.

In 1876 gynecology appeared like a young and brilliant member of the medical profession, well versed in all that was known at that time, but not the mature expert, well trained by long experience—yet enthusiastic, and very anxious to push onward to new and higher attainments.

The literature of gynecology was immature then, but embodied all the best thought and definite knowledge of the age. There were altogether about three hundred printed books which contained the essence of all the science and art of gynecology that had been brought forth in the periodical literature and booklets in the preceding seventy-five years. There was one journal devoted to the subject and one gynecological society in existence and ten obstetrical journals that had gynecological departments. To speak figuratively, gynecology and its literature had passed the infantile period of existence and attained to the age of puberty with all the essential elements in its organization outlined by the developmental processes and surrounded with the nutritive conditions foreboding a phenomenally rapid growth and the promise of a speedy maturity.

The teaching in this department in the preceding days consisted of three or four lectures on diseases of women by the professor of obstetrics, an occasional reference to the subject by the surgeon, and, by way of clinical instruction, the student might be permitted to see the cervix uteri through a Ferguson speculum on several notable occasions. At the time now in review the obstetrician gave about a third of his time to diseases of women. Surgeons also taught some of the operations in gynecological surgery. Indeed, in some of the most advanced medical schools, here and elsewhere, a course of scholastic lectures was given which embraced all of the subject matter or science extant in the literature. Clinical teaching in the schools in general was rather meager still, although a few of the masters here and there gave practical instruction in all that was known twenty-five years ago. Clinical teaching, which was inaugurated in Italy at the beginning of the seventeenth century, made rapid progress and spread all over the scientific world until all branches of medicine were practically taught in an acceptable way in 1876—except gynecology which remained behind. There were many clinical orations on diseases of women given annually, but the practical drilling necessary to make competent practitioners hardly met the requirements.

The differentiation of sex was receiving due attention and the characteristics of woman in all her infinite variety of structure and functions and their relation to health and disease were well outlined in the minds of the foremost gynecologists. The relation of the reproductive system to the general organization had received liberal consideration. The scientific discoveries at this time paved the way for the emancipation of woman in her social, ethical, and political life about which philosophers and philanthropists have had so much to say in later times.

Anatomists had mastered the descriptive anatomy of the pelvic organs before the dawn of gynecology, and some needed information regarding surgical, regional, and transcendental anatomy had been added, so that the gynecologists understood those structures the diseases of which now claimed their attention.

The breath of scientists had blown away the mystical fog that had for ages hung around the function of menstruation. Now it was known to be conducted on the same principles as all other physical phenomena and more rational ideas were entertained regarding its utility in the economy. Still, the histology of the structures concerned, its advent at puberty, the physical necessity for it, the inducing conditions, the laws governing

¹ Read at the twenty-fifth annual meeting (Semi-Jubilee) of the American Gynecological Society, held at Washington, D. C., May 1, 1900.

and the beneficial results obtained by menstruation were being evolved, but not definitely settled.

The methods of observation and detecting organic diseases of the pelvic organs had caught up to physical diagnosis as practised in other branches of medicine and surgery. The instruments previously invented for facilitating inspection were not only useful for diagnosis, but made the procedures in plastic surgery possible—such, for example, as vesicovaginal fistula and injuries of the cervix uteri. In fact, this successful plastic surgery of the pelvic organs and ovariectomy were the triumphs which placed gynecology upon a plane of equality with general surgery.

Diseases of the uterus of the inflammatory and malnutrition order were known in a somewhat indefinite way. The inquisitive had looked beyond the "ulceration of the os uteri," postpartum subinvolution, and leucorrhea and had seen various morbid states, the pathological significance and classification of which were still rather chaotic. The problem of causation of these uterine diseases was being wrought out, but was not completely solved. Many factors, such as germ infection, had not been fully admitted to their proper place in etiology. Owing to this incomplete knowledge of pathology and etiology, uterine therapeutics were limited and somewhat incompetent. This was in keeping with the basic fact that rational treatment has not preceded, but has followed scientific pathology and etiology.

The normal position of the uterus in the pelvis and the physiological limits of its mobility had been comprehensively studied, and the structures which hold the uterus in place, having been investigated by a number of able observers, were about definitely agreed upon. Displacements of the uterus had been all fully described and the causes were still subject to discussion with a near approach to agreement. The treatment of these dislocations was still limited to mechanical means plus restoration of the pelvic floor. The net result was relief in many, recovery in a few, and failures to even help in a considerable number of these cases. Surgery had only played a small part in the treatment of uterine displacements. Pathologists had discovered at the post-mortem table most of the malformations of the uterus arising from lesions of development. Some of these had been recognized clinically and some surgical work had been tried for their relief with results that encouraged farther efforts in that direction. Neoplasms of the uterus, such as myofibroma, carcinoma, and sarcoma, were well advanced so far as the natural history, pathology, and diagnosis were concerned; but the treatment of these was not far beyond the palliative stage with some suggestions or foreshadowing of great potentialities in surgical treatment. I refer to isolated efforts at extirpation of intra-uterine fibroids, hysterectomy, vaginal and abdominal and high amputation of the cervix. Most of these operations were considered at that time to be daring experiments not sufficiently successful to be justifiable operations.

Inflammation of the pelvic areolar tissue and pelvic peritoneum still held a prominent position in the minds of gynecologists. Pelvic cellulitis especially was given the credit of being a very common affection by many, but the most advanced observers had begun to differentiate this affection from inflammation of the oviducts and ovaries, and some of the extremists went so far in that direction that they forgot cellulitis altogether. Obstetricians had noticed that pelvic cellulitis occasionally followed parturition, premature or at term, and they concluded that other pelvic inflammations presenting similar signs and symptoms must be cellulitis. At least, that is the only explanation at hand to account for the delay in getting away from the confusion and confounding of these diseases.

Pelvic hematocele maintained a prominent position in the classification of pelvic disease at this time, but notifications of ejection were being served upon it to make room for ectopic gestation which then had come very impressively to the attention of gynecologists.

Ovariectomy was, no doubt, the most illustrious discovery in gynecology up to this time. The more heroic, competent, and progressive surgeons in this field pointed with justifiable pride to this means of eradicating the ovarian cystomata that heretofore had been fatal, crowding its victims out of existence by cruel and slow degrees. Confidence in the efficiency of ovariectomy as practised by the most experienced operators was fairly well established, not altogether on the results obtained, but on a growing comprehension of the causes of failure and an intelligent hope and prospect of overcoming the stumbling blocks in the way of complete success.

About this time the attention of all medical scientists was concentrated on bacteria and bacilli and the part played by all such germs in the causation of disease—especially sepsis in surgery. Ovariectomists were among the first to practically apply every germ of knowledge relating to aseptic and antiseptic surgery and were beginning to realize some advantages in their war against the infection of wounds in their special branch. A better knowledge of how to make hands, instruments and appliances cleaner, if not quite surgically clean, enabled the foremost of ovariectomists to escape from the dense clouds of carbolic spray that were presumed to purify the air, but at the same time poisoned, to a degree, the patient and operator. Post-operative septic diseases were still too common and hence the operators were obliged to struggle with the problem of cleanliness. Drainage of the abdominal cavity after ovariectomy was much in vogue then, and was of service in cases which had not been left quite clean and complete in all the necessary and possible conditions essential to recovery. The great advantages already attained in anti-bacteria methods gave a sense of security to the operators which was regarded by some so highly that they in some measure neglected the cultivation of dexterity and accuracy in operating and

lost ground to some slight degree just there. Taken altogether, ovariectomy was about the sum total of abdominal surgery successfully practised at that time, and was attended with an encouraging praiseworthy success in simple cases. There still remained much room for improvement in the management of complications and in cleanliness and technic generally. Toward these higher and better ends gynecologists were directing their efforts on scientific lines that had been fully laid out in this field of special surgery. Their energy, industry, and enthusiasm in this regard were most praiseworthy and deserving of success.

While the treatment of ovarian neoplasms was well on the road towards first place in the line of major operations, other diseases of the ovaries and oviducts were still in the hands of the student and clinical investigator. Acute and chronic inflammation of these structures had been discovered, mostly post-mortem, and their pathology described by the professors of morbid anatomy. Gynecologists were discussing the diagnosis, causation, and treatment of these diseases and two or three men had done some startling work in surgical treatment. Nevertheless, the whole matter had not been sufficiently elaborated to insure its unqualified acceptance as mature science and art by all who claimed kinship with gynecologists. If gynecologists left this part of their science and art a little behind, they certainly made up for it in after-times by rushing the matter forward until it threatened to overshadow all else.

Leaving out of account vesicovaginal fistula, vesical calculus, urethral carunculae and cystitis there was little known or said about diseases of the urinary organs in woman by any one anywhere, excepting in Austria where one man of brilliant mental capacity had brought up the subject to the plane then occupied by the other branches of this special department of medicine.

To present a picture that would represent the status of gynecology twenty-five years ago in anything near to a recognizable portrait, requires a bigger canvas, a brighter light, and far more of the painter's artistic skill than has come my way. However, I may borrow from the architect's method of representation and say that the ground to be occupied by the gynecology of the future had been well surveyed, the foundation of the structure had been built by most skilful workmen. The walls had been raised and roofed over. Halls, stairways, and rooms all outlined by framework and partition walls, and most, if not all, of the floors had been laid in mosaic of cubes from every known land. Several rooms were finished and furnished in modern fashion and fit to be occupied by the lords of this new creation. This structure had been named and declared to be worthy of a high place among the older and best mansions of the age. The designers and builders were acknowledged by the censors in medicine to be the masters of science and arts who held the full confidence of the profession.

There were few men at this time who gave their whole time and attention to gynecology and were known as experts or specialists in this branch of practice. There were, perhaps, two or three such in this country and about the same in other nations; a number who had a comprehensive grasp of this special practice with one hand, while with the other they still kept a less firm hold upon obstetrics, general medicine or surgery. All of them were noted, respected, admired, and honored for their honesty, earnestness of purpose, professional dignity, honor and courtesy among themselves and to all professional neighbors. Good natured, normal rivalry in the struggle for higher attainments in their science and art was at white heat, but uncontaminated by business or commercial methods of making a paying reputation.

Turning from this, glance backward upon the past to look at the present, the changes for the better and greater that appear are quite surprising.

The status of gynecology to-day is on a par with that of all other specialties in medicine. This, I presume, is admitted without reservation by all including a few of the obstetricians and general surgeons who claimed gynecology as their offspring which they may have hoped to keep to themselves for all time, that they might exercise a paternal and maternal control over it and share its honors and earnings.

This right and title of gynecology to live and maintain a degree of independence, being based upon its maturity and capability, has put to sleep all jealousy that may have existed and silenced the guns of the critics forever. This surely must be conceded by the most conservative when they witness the fact that to-day the literature of gynecology is as complete, comprehensive, and nearly, if not quite, as ample as that of any other special department of medicine. While there were only three journals and one society exclusively gynecological in 1876, there are now in every city and town the world over one or more journals and societies devoted to this new and youngest department in medicine. And the books have grown in number from 300 to 1000. Verily, the gynecologists have obeyed the injunction, "Be ye fruitful and multiply." In every medical school worthy of the name gynecology is taught by men of known ability. As much time is given to scholastic and clinical teaching as to any other subject, such as ophthalmology and neurology; and professors of gynecology are many, perhaps a little supernumerous.

The mental and physical characteristics of woman and their adaptation to her cosmic relations, the interdependence and harmonious associations of her reproductive organs and general organization are now well understood. Consequently the etiology and diagnosis of diseases peculiar to woman are based on scientific principles, and the treatment is rational, not speculative. Along with this higher knowledge of the structure and functions came the comprehension of the

many derangements of the nutritive and nervous systems caused by diseases of the sexual organs which were called in the past hysteria, but are now known as reflexes and treated accordingly. In this matter much valuable aid has been given by the neurologists to whom due credit should be given. The inscription, which, freely, translated, means "The fellow is a woman because of a uterus," is seldom seen, but instead the present-day saying, "Men and women are equal, but not identical," is heard.

The physiological anatomy and histology of menstruation, the necessity for and cause of it, and the effect of its derangements upon the general economy are all well defined now and make a valuable part of the working capital of the practising gynecologists who have to care for the derangements of this function. The old order of therapeutics of a few years ago, emmenagogues for amenorrhea and astringents for menorrhagia with a liberal amount of gin for dysmenorrhea are forgotten. Puberty and the menopause, which were discussed in a few pages of some works on diseases of women, have been fully elaborated, so that now the latter is the subject of two books that are monuments to the industry of their authors and a benefaction to women.

The present status of methods of investigation and observation shows a marked improvement—or, rather, a growth in refinement and accuracy which is quite abreast of that of other departments of medicine.

The closure of vesicovaginal fistulæ and the repair of injuries of the pelvic floor, referred to as the top leaves of the tree of knowledge in pelvic surgery twenty-five years ago, have been supplanted by vast improvements in perineorrhaphy and many new surgical procedures which to-day fulfil nearly all requirements. Moreover, in the past there were few successful operators in this part of restorative surgery. Now they are plentiful as coal-tar products in the materia medica and many of them are competent.

All that was obscure and indefinite regarding inflammation of the uterus twenty-five years ago has been cleared away and now metritis in all forms, degrees, and varieties—with their septic, specific, traumatic and other causes—are all well known. Much light has lately been thrown upon all pelvic inflammations by investigations of the bacteria, native and foreign, found in the vagina and uterus, and, what is more pertinent at this time, many of these discoveries have been made by gynecologists. The causative relations of neoplasms and post-partum and menstrual subinvolution to metritis are settled questions. Clearer ideas regarding pathology and causation have led to more scientific treatment. The routine applications used in the past for all morbid conditions of the endometrium are forgotten. At this time all forms of uterine diseases are treated according to modern surgical and medical therapeutics which give results that might make the older gynecologists wish that their birth had been deferred a quarter of a century.

Equally strong lines and high light may be used in sketching the present status of displacements of the uterus. There is now more harmony of opinion regarding the normal position of the uterus, the agents which keep it there, the causes of displacements, and the structural changes in other pelvic organs and tissues which follow in the various degrees and forms of dislocations. Much as there is in this, it is little compared with the matured state of the treatment of uterine displacements. Mechanical support practised in the past, which generally relieved, sometimes cured, and often failed entirely, has largely been supplanted by a number of surgical procedures which, as practised at the present time, succeed in giving relief as often and as surely as failures occurred in the past.

Flexions of the uterus are closely related to displacements of the uterus, although many class them as malformations and treat them on that basis. Whatever opinions may be held regarding the pathology of these affections, their treatment is far in advance of that of the past. Incision and discussion of the cervix and dilation with that abomination, a sponge-tent, was the exclusive surgical treatment, but to-day the old has given way to new and vastly more satisfactory surgery. It may not be too much to say that the cure of a flexion of the uterus and its incident complications was an exceptional result of the treatment of that day, and now successful treatment is the rule.

Regarding for a moment neoplasms of the uterus, one has only to contrast the treatment of myofibromata in the past and present to be able to appreciate the extraordinary advancement. Pedunculated fibroids that had found their way into the vagina were removed and some of the leading operators had enucleated intra-uterine tumors, but not with encouraging results. This was about as far as surgery went in this direction. To-day the gynecologist, with his success in abdominal and vaginal myomectomy and hysterectomy, is now master of this field which he only entered twenty years ago. Similar, although less marked, is the reputation of the surgical treatment of cancers of the uterus at this time compared with the past.

Pelvic cellulitis is very rarely heard of now except as a puerperal disease resulting from some old-time obstetrical practice.

Pelvic peritonitis has also fallen from its high position to that of a secondary affection, having little interest compared to the preceding diseases which cause it. Pelvic hematocele also has been crowded almost entirely out of the mind of the gynecologist to make room for ectopic gestation to which so much profound consideration has been given, and for which so much is being done to save the victims of this strange blunder in reproduction.

Ovariectomy and bacteriology (in its relation to the causation of disease) were as school children, strong and prosperous for their age in 1876, and they have grown up together to a well-round-

ed maturity. The improvement in ovariectomy has been mostly in the direction of successfully dealing with all kinds of complications and notably intraligamentous cysts and injuries to the ureters and intestines. The making and closing of the abdominal wounds and the protection of exposed tissues by the present methods of cleanliness in surgery have all been brought up to such a high plane of perfection that the only question remaining now is, shall the subject be handled with or without gloves?

The other diseases of the ovaries and oviducts, that were only known to the pathologists because they were generally incurable and often fatal, are now quite familiar to the gynecologist and as completely under his control as anything in his practise. Opening a pelvic abscess through the vagina was about all that the surgeon dared to do in the early days of gynecology. Now diseased tubes and ovaries are extirpated with a facility and certainty of success that surpass all that was ever dreamt of, or hoped for, by the prophets of early days. In fact, abdominal and vaginal ovarosalingectomy are among the most valuable and highly prized procedures in this branch of surgery. The only question one hears discussed at this time is the relative advantages of the vaginal and abdominal avenues of approach to the field of operation in certain conditions.

Diseases of the urinary organs in women have lately claimed much needed attention which has placed the subject upon the same plane as that of the most highly cultivated branches of gynecology.

These brief, incomplete references to a few of the prominent features in the picture of gynecology at the present time may enable one to see the whole subject as it appears before the profession and the public to-day. The gynecology of twenty-five years ago was likened to a recent graduate, well versed in the rudiments and having clear impressions of the general subject, but having limited power of expression, knowing much of what should be done, but having little ability to do. Meantime impressions have been multiplied and executive ability has grown in proportion until now gynecology is great enough to hold its place among the specialties in medicine and big enough to monopolize the full capacity of any brain—even although a little above the average in size and activity. Referring to the architectural simile employed to represent the status of gynecology at the advent of this society, it may be said that the rooms in the structure that were empty are now fully furnished in a scientific and artistic style, embracing all the modern improvements. Plans have also been made for large additions in the way of hygienic and protective medicine.

Regarding the character and standing of gynecologists at the time when this imperfect little description began, it is true and well to say that there were giants and gentlemen then—learned, dignified, earnest men who were just, courteous, and observant of all that is best in pro-

fessional ethics and etiquette, regarding always the rights of others as equal to their own. To-day gynecologists, both amateur and professional, are far greater in number, but evidently not superior in ethical culture and altruism. They may be better in this respect than they appear to be. Owing to overcrowding, the gynecologists in their struggle for a living may fail to respect their neighbors as they do themselves—although they may still have the inherent desire to do so although eyes that were used to the light of the past fail to see it.

These remarks are given from my memory of the past and my impressions of the present and are, therefore, incomplete and, to some extent, inaccurate. I had no time to give the names of the men who made gynecology and give credit to each for work well done. This, however, is not necessary in addressing you who know well to whom the honors are due.

Finally, an unbiased study of the part played by this country in the evolution and actual life of gynecology enables one to keenly feel, without a shadow of the arrogant or vainglorious that, in the discoveries, development, and growth of gynecology this country has been and is now first among the foremost—and this Society for the past quarter of a century has been and is now the representative of all that is indicated and comprehended in its name.

THE PHARMACOPŒIA OF NINETEEN HUNDRED.¹

BY HORATIO C. WOOD, M.D.,
OF PHILADELPHIA.

IN the thought of the Infinite it may well be that in unbroken sequence event follows event from infinity to infinity, but man, bound to time by the limitations of his own existence, for his own purposes arbitrarily breaks the monotony of progress and calls the larger fragments years, decades, centuries. To-day the tally of the decades is full, and assembled here together we stand upon one of those great mounds which mark the passage of a century. Looking forward as a traveller who has reached some high dividing summit we strive to peer into the future, but its mists are impenetrable, and what seems to our straining vision the outlines of figures are but the projected shadows of the present. The view behind is plainer; the roads by which we have reached the summit are crowded with footsteps, in the near-by sharp and distinct, and fading with the distance. Under such circumstances it is but natural that the opening address of your President should take an historic tinge, and that before we settle down to work we should try to draw from the past such lessons for the present as shall make secure the future. Such retrospect is especially fitting since our labors, when they shall be carried to their end, will finish the first

¹ President's Address to the Committee of the Revision of the U. S. Pharmacopœia, Washington, D. C., May 2, 1900.

century of Pharmacopœial work in the United States.

It is true that, as told in the historical introduction to the Pharmacopœia, there was published in Philadelphia in 1778, for military purposes, a small Pharmacopœia; but it was the Counsellors of the Massachusetts Medical Society who, in 1805, first appreciated the need in America of a general Pharmacopœia; and it was the result of their labors, issued in 1808, that suggested to Dr. Lyman Spalding of New York City the formation of the National standard.

The dry-bones of history, such as may be found in the opening pages of the U. S. Pharmacopœia, interest most of us but little, but, when they are clothed with flesh and blood, it quickens heart-beats to see how near akin the men of the past were to the men of the present; and how, notwithstanding all change, the continuing brotherhood of the race reveals itself in the written lines.

In 1874, profoundly impressed with the rapid multiplication of medical books, and the phenomenal growth of medical literature, I wrote in opening the preface to my book on Therapeutics: "Indeed, art is so long, life is so short, that every student has the right to demand of an author by what authority he doeth these things, and to challenge every memoir for its *raison d'être*."

Judge of my surprise, when recently looking over the Pharmacopœia published by the Massachusetts Medical Society, to read among the first sentences, "Books multiply so fast that it has become necessary to preface every new work with reasons, indeed, almost an apology, for its appearance." This in 1808, when America was little else than wilderness; when, as we view the matter, neither medical journalism nor medical literature existed in the United States.

Very far from the truth is Tennyson's antithesis between the permanence of the brook and the momentary life of humanity; the fact is that the stream of mankind "flows on forever" as much as does the current of the brook; only as the drops of water in the brook change moment by moment, so do the drops come and go in the great human stream; and almost as like as drops are to drops so is man to man. 'Hands from which had scarcely fallen the gauntlets of Puritanism, wrote in primeval New England, "It must not be understood that in adopting the modern language of botany and chemistry we have consulted the whims of every pretender. In this as in former ages men are creating confusion by creating names."

Wise words are these, which the coming Subcommittee on Nomenclature of the U. S. Pharmacopœia should ponder a little more seriously than have their immediate predecessors. "In this as in preceding ages men are creating confusion by creating names." Applicable is this to all sciences, but most applicable is it in the purely natural history studies, so-called, such as zoology and botany. Smith, or Jones, or Thomson, or Cope, written at the end of the name

of an animal or plant, fails not in its influence on human personality. I well remember with what glee and pride in the days of my callow youth, when I should have been under the taskmaster's learning methods and facts, I first saw H. C. Wood written after the name of a piece of fossil drift-wood from the coal fields of Pennsylvania. The boy is the father of the man. Unconsciously there remains in each of us some capacity of enjoyment such as was in the boy who, pointing to his name in the newspaper, said to his old aunt, "That's me." If the personal element could be withdrawn from the specific nomenclature of animal and plants there probably would be much simplification. Let it be said of none of us that we have created confusion by creating names. Why must the poisoned American perish while we are searching our memories for *ferri oxidum hydratum cum magnesia*, when *antidotum arsenici* might have saved his life if only he had lived in Germany?

In the preface of the Pharmacopœia of 1808 it is interesting to find the germs whose subsequent growth has cost the members of this Convention and its Committees so much labor. In accordance with the statement in the preface, "As there frequently arise errors of no small importance from the promiscuous use of weights and measures, it is proper that the quantities of substances, whether fluid or solid, be determined by weight." In accordance with this the framers of the first American Pharmacopœia adopted the system of parts by weight, but unfortunately they went on to say, "Yet it may suffice to measure wine, water and aqueous liquids in some instances, provided that for this purpose vessels be employed, of glass where the nature of the substance requires it, whose capacities and divisions accurately correspond with the divisions or multiples of the modern pound."

So saying, our fathers sowed the tares which grew up with the wheat, and choked out the true grain until only by the labors of many years were they up-rooted and the system of parts by weight in its purity reinstated in the U. S. Pharmacopœia. The tares grew rapidly, for in the second edition of the Pharmacopœia, that of 1820, fluid measures were employed. The sin of the men of 1820 in changing from parts by weight to liquid measures of quantity was made greater by the fact that the liquid measures were not at that time in use among the apothecaries of America. That the amblyopia of the revisers was not deeper than that of their contemporaries is, however, shown by the following extract from a contemporary review of the National Pharmacopœia in July, 1821: "If the American Pharmacopœia be adopted throughout the United States, as no doubt it will be, these modes of indicating quantities must necessarily come into use, and that they will be continued after having been introduced we do not hesitate to affirm, because they are more definite and precise, and consequently safer than the old methods. In such case it will be necessary that the

apothecaries be provided with the measures above mentioned."

The language of the Massachusetts Pharmacopœia of 1808 was English. The first United States Pharmacopœia of 1820 was printed in Latin, with a translation of the Latin into English upon the opposite page; and the Convention of 1830, in not departing from the use of Latin, justified itself in the language of the preface because "the Latin, if not essentially necessary, may prove highly serviceable by fixing the precise meaning of an English phrase which might not otherwise be well understood." Fancy an American apothecary or even an American doctor of the present time, when he could not understand the exact meaning of the English turning to the Latin to clarify his thoughts!

The Pharmacopœias of 1820 and 1830 were prepared by the Conventions themselves, these Conventions being composed solely of physicians. In 1840 the growth in numbers of the Convention necessitated the reference of the detailed work of Revision to a Committee, and the method still in vogue was inaugurated. The same Convention made itself further historic by the determining that the Convention to be called in 1850 should be composed of the two professions of Medicine and of Pharmacy, by whose co-union in labor the continuance of the Pharmacopœia of the United States as an authority has been made possible.

Since 1840 the great part of the labor revision of the Pharmacopœia has fallen upon the successive Chairmen of the Committee of Revision. In sixty years of these labors there have been only four, namely, George B. Wood, from 1840 to 1860; Franklin Bache, from 1860 to 1870; Joseph Carson, from 1870 to 1880; Charles Rice, from 1880 to 1900. As no revision of the Pharmacopœia has been more successful than the last, and as at no time have the necessary duties of the Chairman of the Committee been as great as they are at the present, so never in the century has there been found a man more laborious, more conscientious and painstaking, or better fitted by extraordinary acquirements and personal qualities to fulfil the onerous duties of the position than the present Chairman; and your President most earnestly hopes that by his continuance in office the success of the next revision of the Pharmacopœia may be ensured.

During its whole life the United States Pharmacopœia has received no governmental support, and has been free from governmental control. Under the circumstances the influence which it has exerted upon the pharmaceutical and medical professions and the voluntary obedience which has been given to it are not only a tribute to its practical excellence but also a strong evidence of that peculiar Anglo-Saxon power of recognizing authority which is not upon the statute books; a power born of self-control and common sense which makes the race of all others most capable of self-government. The indirect recognition by the Government of the Pharma-

copœia becomes each year more apparent both in Federal and State legislature, so that there does not seem at present any danger of the Pharmacopœia losing its control in the United States.

The Pharmacopœias which have been produced in the United States by voluntary effort both in the past and in the present contrast favorably with the governmental standards of European countries. In its scientific accuracy, in its general usefulness and in the efficiency and elegance of its resulting preparations, our Pharmacopœia is the peer of the best. I am not one of those who are conceited in things American, freely acknowledging that we have added very little to the great sciences which underlie the practice of medicine, and that we have been indebted to Europe for almost all of our fundamental inspirations, I still hold most strongly to the belief that there are no therapeutics superior to the American therapeutics, and that in no country has pharmacy been carried to the perfection that it has reached in the United States.

Delegates of the Pharmaceutical Associations, I congratulate you on representing a profession which has attained its highest development in the United States.

There is a probably widespread, and certainly often spoken of, feeling that the medical profession of the United States does not properly appreciate and support the U. S. Pharmacopœia. There is some foundation for this feeling, but certainly it is exaggerated. It is true that—owing to the activity of manufacturing pharmacists and the number and skill of their commercial salesmen (vendors of samples), aided by the deficiencies of medical education and the peculiar childlike credulity which is so common in doctors—all kinds of proprietary mixtures and proprietary articles, and extra-pharmacopœial remedies are largely used in the United States. It is so easy for the lazy doctor to write for Smith's Panacea for Human Ills, and so easy for the doctor who knows neither *Materia Medica* nor Therapeutics to order Jones' Consumption Cure or Thomas' Kamiantia, that so long as laziness and incompetence remain with us so long will this thing be done. But this is no fault of the Pharmacopœia, and no perfection of the Pharmacopœia can greatly influence it.

Certainly any attempt to reduce the products of the Pharmacopœia to the level of the proprietary or patent medicine would be to destroy the dignity of the work, to bring it into contempt, and finally to uproot its influence. Under the influence of State law and of public opinion the average education of the American medical profession is rapidly and steadily rising; in this and not in anything that this Convention or its Committee can do lies the hope of the future. Moreover, the intensity of the feeling that the American medical profession is not as thoroughly interested in the Pharmacopœia as it ought to be rests largely upon a misconception of the intent of the Pharmacopœia, and its relations to the

medical profession. A Pharmacopœia is not intended to be a guide to practice, or a working-book to be used by the doctor, but is really the hand-book of the apothecary. I do not believe that at any time or in any country Pharmacopœias ever have had much sale among the medical profession; and each year, as the professions differentiate themselves more and more, as the doctor becomes less and less of a pharmacist, the tendency of the doctors to buy Pharmacopœias must grow less rather than more. The Pharmacopœia can only be popularized in the medical profession by making it a treatise on Therapeutics; in other words by causing it to cease to be a Pharmacopœia. So long as it is a Pharmacopœia it is the basis upon which textbooks and Dispensatories are to be written; and it becomes through these treatises a guide to the medical profession. It remains the apothecary's *vade mecum*, with which in hand he does his work, and its sales must be chiefly among the apothecaries.

There may have been a time when the medical horizon was so narrow that the doctor had time to trouble himself as to how the druggists made laudanum, but at present the doctor has as much as he can do to store his mind with purely medical facts; he wants simply to know what laudanum does when he puts it into the patient, and he trusts the apothecary to give him laudanum when he calls for it.

Be these things as they may, it is certain that the present condition of the U. S. Pharmacopœia is one of great prosperity. The book itself ranks with the best of its predecessors or of foreign Pharmacopœias, representing all that was possible in 1890. Its hold upon the people of the United States is more firm than it ever was before. Its sales have far exceeded those of any previous edition, and for the first time in the history of this Association the treasury is overflowing. Indeed, so rich have we become that the greatest danger which threatens the Association is, to my thinking, surplus of revenue.

Standing on the Great Divide between the centuries, viewing the Past and the Present, what lesson can we draw that shall help us to make sure the Future? Is it not that we shall push straight out the old paths? For one hundred years they have been trodden by successive generations, who have found them sure roads to scientific advancement and practical success. Why should we depart from customs whose soundness has been time-proven?

It is a remarkable fact that during a century of successful life this Convention or Association has had no written fixed law for its government. Largely for this reason certain errors have grown up and received widespread adherence as to the nature and scope of this body. Thus, many persons are inclined to look upon each meeting of the Convention as a separate and distinct Association, and even to consider the Committee of Revision as an independent body. The fact is that the Convention for the Revision of the

United States Pharmacopœia is a continuing Association, parallel in its nature to the American Medical or the American Pharmaceutical Association, or other similar organization, the sole difference being that the period between its meetings is ten years instead of one year, as is usual. The Convention should really be spoken of as an Association; it is continually alive through its officers, whose duties never cease and whose positions are never vacant unless it be for the moment of change of occupants during the session of the Convention. The Convention is further always active through its Executive Committee and Committees of Revision and Publication, so-called, to which, as agent, the Convention delegates its powers when not in session.

The growth of this Association in numbers, in influence, and in wealth, has seemed to me to make it imperative at this time that what has been tradition and the growth of custom should be clothed with the fixedness and authority of written law, and that a written Constitution and By-Laws should be adopted.

The growing responsibilities of ownership and of business make it further essential that this body shall in some form or other be incorporated. It seems to me also necessary that a slight alteration should be made in our working methods; an alteration which is, however, not so much a change as a development. The present Committee of Revision and Publication has, as its name implies, two offices or functions which are entirely distinct; the one being concerned with the preparation of the Pharmacopœia, the other with its publication; the one requiring on the part of the Committee that has charge of it scientific knowledge and practical skill in medical and pharmaceutical matters, the other business judgment and activity.

It is certain that a scientist may also be a business man, but the scientist is in reality no more frequently a business man than the business man is a scientist; and so it has come to pass that in order that its personnel shall include men of business, of science, of medicine, and of practical pharmacy, the Committee of Revision and Publication has been composed of twenty-five members, a number which makes it cumbersome, wastes the time of the Chairman, and achieves results no better than would be obtained with much less labor by a smaller body.

The proposition which I have to offer for the consideration of this Convention is that this double Committee shall be divided into its component parts, and that out of it shall be made two Committees, one to prepare, the other to publish, the Pharmacopœia. Let the new Committee of Revision be composed of twenty members, and let the Convention nominate five members, who, with the President of the Convention and the Chairman of the Committee of Revision, after they shall have been appointed, shall constitute a Board of Trustees which shall have charge of the financial and publishing business of the Convention.

The experience of the last decade seems to make this imperative. A considerable sum of money has been very properly spent in the paying of experts for research work, but there are many members of the Committee of Revision who have done work greater in quantity and in importance than any of these investigators, who yet have received no compensation for their services. Why? Because gentlemen do not vote money to themselves out of public funds, even though it may have been properly earned.

Let me give you a concrete instance. Professor Maisch went over all the *Materia Medica* definitions of the *Pharmacopœia*; with his great knowledge and with a splendid *Materia Medica* Museum at his command he spent hours and days rectifying, enlarging, and perfecting the definitions of drugs until probably they are the best ever written; for which no compensation has been awarded him or his heirs. One of the duties of this Convention certainly is to set aside or in some way make provision for the payment of such services, but it is always better to be just during the time of action than to atone afterwards for an injustice; and if a Business Committee is formed by this Association it can determine the relation between the value of services rendered by the members of the Committee of Revision and the power of the Convention to compensate. If it be thought desirable, this Business Committee or Board of Trustees may be made to constitute, with the officers of the Convention and the Committee, a general Council, who shall represent the Convention in large matters, such as the decision of whether an extra edition of the *Pharmacopœia* shall be published in 1905, or whether in some emergency the Convention should be reconvened.

Time is failing, but I think it must be evident to everyone without further discussion that it is essential to separate that which is business and financial from that which is scientific and practical pharmacy; and that this Convention can best attain this object by having two distinct Committees.

Having adopted Constitution and By-Laws, appointed officers and the two Committees, this Convention should give instruction to the officers and the two Committees together to incorporate the Convention. I am told by eminent counsel that there is no legal difficulty in the way, only it must be clearly stated in the Constitution that a delegate from one of the bodies entitled under the Constitution to representation becomes by virtue of his election as a delegate a member of the incorporated body, and loses his membership when he ceases to be a delegate.

Finally, gentlemen of this Convention, a word and I have finished. As the American nation of 1800 seems to us to have been but a handful of seed from whose growth we are the fruit, so will those who meet here in the year two thousand think of the American people of to-day as a small body from which they have themselves sprung. We live but for the moment; one hun-

dred years from now only the greatest of us will remain as fading memories; as men whose records have been so over-written on the palimpsest of time that only here and there can a sentence be deciphered. So it ever has been and so it ever shall be with the human race; men come and go and are not; but though the worker disappears and is forgotten the work lives on. Our fathers labored and we have entered into their labors. Let us see to it that preserving in its essential lines that which has come to us, and adding to it in our day and generation as strength is given us, we may leave for the coming century good work and true, which shall remain as the abiding though unrecognized witness of our earnest living.

THE TREATMENT OF SUPPURATIVE OTITIS MEDIA IN YOUNG CHILDREN.*

BY GEORGE L. RICHARDS, M.D.,
OF FALL RIVER, MASS.

OTOLOGIST AND LARYNGOLOGIST TO THE FALL RIVER AND EMERGENCY HOSPITAL; FELLOW OF THE AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, ETC.

THIS subject is presented in order to bring about the discussion of an important pathologic condition and not because I myself have anything especially new or novel to offer in the way of its treatment. From my own experience I am convinced that the average practitioner does not yet sufficiently realize the possible dangers to the child which lie in a suppurative ear. If he did there would not be as many suppurative ears in young children, which starting as acute conditions, become chronic and last weeks, months and years.

That their number is very large it is needless before this Society to attempt to prove; our personal experience is proof sufficient. I think we shall also be as ready to agree that they are frequently overlooked. Rasch¹ reports from the hospital in Copenhagen that in 61 necropsies evidences of otitis media were found in 61 of the children; of this number 32 had true abscesses in both ears. Ponfick² reports that in 100 consecutive autopsies of children dying from various diseases, the ears of only 9 per cent. were normal; in the remaining 91 per cent. a well marked otitis media of a purulent or muco-purulent character was present. While these statistics are those of foundling hospitals, where the children frequently are, or have been poorly nourished, and are not, therefore, to be compared absolutely with the statistics which would follow from an equal number of children taken from an ordinary community, they nevertheless show that otitis media purulenta is very common and is not estimated at its true importance. The recent valuable paper of Pomeroy³ shows how possible and even easy it is to overlook acute otitis media in the young child previous to the time of any discharge. In many of these cases the objective symptoms

*A paper presented to the American Laryngological, Rhinological and Otolaryngological Society (Eastern Section) at its annual meeting in Philadelphia, February 17, 1900.

pointing to the ear are but few, and frequently vague or entirely masked. Even after suppuration is apparent the condition is frequently either entirely overlooked (and this was the fact in many of the cases the statistics of which I have quoted), made light of, or dismissed with the injunction to the parent to keep the child's ears clean.

Those of us who see a good many of these cases know how effectively the cleaning process is carried out. Usually it is a complete failure. We have all examined the ears that the mother tells us have just been cleansed only to find in the canal or tympanic cavity, or both, pus of so foul an odor as to be unbearable to any self-respecting nostril.

The causes of these suppurating ears in young children are various, but may be fairly easily classified into those dependent on the exanthemata and other contagious diseases; those dependent on positive pathologic processes in the pharynx and nasopharynx, as adenoids and enlarged tonsils; those dependent on the extension of catarrhal processes of the nose and nasopharynx, and those due to colds and exposure, starting as a simple acute otitis media of local origin. The child goes through the stages of an acute or sub-acute otitis, with earache, deafness and other symptoms belonging to the condition, followed by a discharge, at first serous, then sero-purulent and finally purulent. With the cessation of pain the matter is frequently forgotten by both physician and parent, and sometimes the physician's attention is not called to the case at all. When it is, some very vague directions are given as to the necessity of keeping the ear clean. The cleaning process is attempted, but the discharge continuing, becoming foul and the child being increasingly deaf, the specialist's aid is after a longer or shorter time sought. The ear is then thoroughly cleansed and appropriate treatment instituted, which, if carried out systematically, usually produces rapid and brilliant results; although it is also true that in the occasional case the suppuration continues in spite of our best endeavors, and before a cure is effected the aid of more radical surgery has to be invoked. To be effective the treatment must be frequent and the tympanic cavity kept free from any accumulation of pus and micro-organisms.

How is this to be brought about? All must have felt, as I have felt, the inability of the mother to bring the child to the physician's office for the daily treatment, not only on account of the expense, but also because of the trouble of taking the child daily to the office, to say nothing of the time consumed. Any one who has ever waited from one to three hours, in the office of some busy physician, for his or her turn knows that this question of the time consumed has its weight. How, then, can we teach the mothers or nurses of our patients so that they can intelligently care for the ear, whose treatment we have begun, and properly assist in the endeavor to restore it to health?

Premising that I am now chiefly concerned with the *strictly local treatment* of suppurative otitis, although in each case regarding the constitutional treatment as of the greatest importance, always to be carefully looked after and appropriate measures instituted, I will outline the method I am in the habit of using, which varies a little according to the length of time the suppuration has lasted and the degree of damage which the ear has already sustained. If the suppuration has lasted some time, the discharge very foul and caries of the tympanic structures already marked, I syringe the ear thoroughly with warm sterile water or with a solution of 1 to 5000 bichloride of mercury until all debris has been removed. The canal is then carefully dried and the ear inspected. If there is much destruction of the tympanic membrane, I apply peroxide of hydrogen on a cotton pledget (never dropped in) as long as there is any exudation of gas, and after again drying the parts, apply on a cotton pledget a saturated solution of boric acid in from forty to ninety per cent. of alcohol, the percentage of the alcohol depending on the age of the child and the ability to bear the pain of the alcohol. In young children I seldom use over fifty per cent. alcohol. I next dust the whole surface *lightly* with powdered boric acid or some similarly acting powder; of late I have been using boric acid and acetanilid with good results, also at times aristol, acetanilid, or euophen combined with stearate of zinc. These are all drying powders and I regard them as very useful, although some object to the use of powders at all. A powder can, however, be used with perfect safety in the ear if care is taken not to use too much and the powder is free from lumps. Lastly, I lightly stopper the ear with a small narrow wick of iodoform or other antiseptic gauze, taking care that the gauze reaches to the bottom of the canal.

If the process is more acute and the perforation small neither the peroxide of hydrogen, nor the boric-acid alcohol, nor the powder is used; but simply as thorough cleansing as possible through an opening in the drum membrane large enough to ensure drainage, with the insertion of gauze-wicking or cotton pledgets frequently changed in the manner to be described. If there is the slightest doubt as to the opening being large enough, a free incision is made at the posterior inferior quadrant of the drum membrane. This will often be found advantageous even when drainage is apparently good.

The office treatment is now apparently ended but the most important thing is yet to come, namely, the instruction of the mother or the attendant in the home treatment. This I regard as important as, if not more so than, my own and without which my endeavors are very likely to fail. With the aid of a diagram I show the mother a little of the anatomy of the ear, explaining that the floor of the middle-ear cavity is lower than the external outlet and that consequently natural drainage must of necessity be very poor. I tell her that drainage is what is wanted and

that it is absolutely essential, inasmuch as the matter retained in the ear is very destructive and is liable to produce permanent deafness or even death from extension to the neighboring regions of the brain and the mastoid process; and not infrequently I show her on a temporal bone how close the floor of the brain is to the roof of the tympanic cavity. I explain the necessity of keeping the ear clean, clear to the bottom of the tympanic cavity and show her that the wad of cotton which she had stuffed into the ear when she came serves only to retain the secretions, while being absolutely worthless as far as any drainage is concerned; that in effect it as completely locks up the secretions as though a cork had been inserted. She is now ready to receive directions for the home treatment and sufficiently interested and impressed to try and follow instructions to the letter. While I much prefer gauze drainage to any other, where it can be properly inserted, I do not as a rule order it for the average case simply because it is impossible to properly place gauze wicking in the ear without a suitable forceps and under fairly good illumination, neither of which conditions are apt to obtain in the home.

I take a knitting needle with the ends roughened by a file and carefully show the mother how to loosely but firmly wind a piece of cotton on the same with the end projecting a quarter to half an inch beyond the needle tip, far enough so that no harm can come to the ear from its use when gently inserted. A tapering wooden toothpick or any long, slender object with roughened surface will answer as well. To avoid the slightest possibility of doing any damage with the applicator I instruct the mother to hold the applicator so that it can not possibly be pushed into the ear beyond a safe distance and show her what this distance is. Taking the child before a good light I illustrate how drawing the cartilage of the ear backward straightens the canal, and show her how to insert this cotton pledget to the bottom of the canal, warning her against the most frequent cause of failure, the taking of too large a piece. I tell her on the following day, or as soon as the wick put in by me is soaked through, that she is to withdraw it and then wipe out the canal way to the bottom, as taught. This is continued with fresh pledgets until the tip of the pledget is no longer moist. She is then instructed to take as much of the powder ordered for her as will go on the tip of a small penknife and, through a bit of rubber or glass tubing, blow the same into the ear. If the perforation is a good-sized one and considerable caries is present, I frequently have the boracic-acid alcohol drops also used at home. Finally, the mother inserts a small narrow pledget deep in the ear and withdrawing her needle with a backward twisting motion leaves the cotton in the ear. As, unlike the wicking, this will not withdraw the fluid with as ready capillarity, I order this procedure done from one to three times a day, according to the severity and activity of the

process present and direct that the child be brought to me in from three to seven days. No home syringing is allowed in this method and I am certain that the results are more rapid and satisfactory than when I directed that home syringing be done, although I know that men of much larger experience than myself advise the frequent use of the syringe and regard the method I have outlined as unsatisfactory. In my experience home syringing is seldom satisfactorily done, nor is the canal properly dried afterward; and if not dried thoroughly the remaining fluid is a damage rather than an advantage since it favors the more rapid growth of micro-organisms. Again, the syringe used is frequently not a proper one for the purpose, nor can the very poor always buy the right kind of syringe.

Be that as it may, the method here outlined, when carried out in all its details, is applicable to rich and poor alike and is productive of good results; the details are essential to its success. In a word, cleanse and treat the ear yourself as may be necessary and have that treatment made efficient by the aid of thorough home treatment. I may add that I treat all discharging ears on about the same principle, acute as well as chronic, the details varying with the degree of involvement of tympanic structures and the amount and character of the discharge; as before stated, the peroxide, boracic-acid alcohol and powder being omitted in the acute cases.

Nothing here mentioned is to be considered as opposed to such operative measures as may be needed for the correction of nasal, nasopharyngeal, or pharyngeal conditions which are causative or contributory. These should receive early attention. The more chronic cases and those with complications, as cholesteatomata and marked destruction of the ossicles, will have to be directly considered from the operative standpoint. Even these cases are frequently susceptible of great improvement when treated as I have indicated, and those refusing operation so much benefited as to apparently make an operation seem to be unnecessary.

After several years' observation of a large number of cases I am opposed to much syringing in running ears, whether acute or chronic. It is at times necessary and no doubt there are cases where the syringing produces more rapid results than the dry treatment; I prefer, however, in the main the dry method. I would teach this method in all its details if it were possible to every practitioner, and when a running ear comes under his observation would have him teach mother or nurse how to keep it drained. I prefer gauze drainage, changed as often as soaked through, where skilled supervision can be had, but where it cannot, and these are the great majority of all cases seen by us, I believe that any fairly intelligent person with no more armamentarium than some absorbent cotton and an applicator, either knitting-needle, tooth-pick or something similar, and some antiseptic powder, and this last is not absolutely necessary, can keep

any suppurating ear nearly, if not quite, clean. In most cases the discharge will rapidly subside and many an ear may be saved. Wherever there is discharge of fluid from the ear, what is wanted is drainage. Whatever method will best bring that about is the best treatment.

It may be asked what is to be done with the unruly child, the child who will not allow its ear to be treated? I can only answer by remarking that it all depends on how the parents look at the matter. If the permanent well-being of the child is to take precedence over his present wishes then a way can be found to follow out the instructions given. Most children, after finding that the procedure is not a painful one, will readily permit it without making much fuss. The exceptional child must be held. With the aid of a second person, who will hold the child's head firmly against the side of the body, the other person can do the dressing readily enough. The arm thrown around the head will hold it firmly, whereas attempts to hold a child's head by putting one hand in front and one behind are generally failures.

84 North Main Street.

BIBLIOGRAPHY.

- ¹ Jahrbuch für Kinderheilkunde, Bd. 37, p. 319.
- ² Berlin. klin. Wochenschrift, 1897, No. 28.
- ³ Boston Med. and Surgical Jour., Jan. 18, 1900.

CLINICAL LECTURE.

FIBROID TUMOR OF UTERUS; ENTEROPTOSIS; RETROVERSION; RUPTURED PERINEUM—OPERATIONS—RECOVERY.

By MATTHEW D. MANN, A.M., M.D.,
OF BUFFALO;

PROFESSOR OF OBSTETRICS AND GYNECOLOGY IN THE MEDICAL
DEPARTMENT OF THE UNIVERSITY OF BUFFALO; GYNECOLOGIST
TO THE BUFFALO GENERAL HOSPITAL.

Fibroid Tumor of Uterus.—This patient is fifty-one years of age; married; has seven children, the last born fourteen years ago. She has had the trouble of which she complains for about a year. The symptoms are, first, flowing, which is at times very severe, clots sometimes passing. As a general thing she uses five napkins in twenty-four hours, which is the mark of rather hard flowing. The flowing is worse some days than others. Sometimes it lasts a week; this summer it continued steadily for two months. She is flowing less since she entered the hospital.

The next symptom is pain in the back and in the groins, especially on the right side. She cannot exercise because it "hurts" her. She gets out of breath easily, as in walking up stairs. Some days she is troubled by having to pass water too frequently; she often has to get up during the night for this purpose. Her bowels are constipated, and laxatives are a necessity. The patient has good color, is not thin, but looks quite robust. However, in these cases of pelvic trouble appearances are apt to be deceptive, so that one

can rarely tell much from the expression and general looks of such a patient. From what she tells us, we are led to suspect that one of four different conditions may be present, *viz.*, fibroid tumor, carcinoma, endometritis, or mucous polypus.

Her flowing is *not* due, by the way, to the approach of the menopause as some of you may think. The menopause is the normal cessation of menstruation; it is not a disease, but a physiological process. It is a very common error to conclude that, because a woman's menopause is approaching, she will flow more than usual. The opposite should be the case. But a woman with some disease of the uterus which produces flowing will be apt to flow more at this time. Thus we have four conditions which may, under these circumstances, produce the symptoms of which the patient complains, a fibroid growth, a malignant growth, a polyp (and polypi occur very frequently at this period of life) or an endometritis. How can we decide between the four? The only sure way is by examination. When I made my examination I found that she had a tumor, probably as large as a baby's head, to the right side rather than to the left. This is firmly attached to the uterus and not tender. It presents all the evidences of a fibroid growth.

Suppose there were no fibroid and no disease of the cervix, and we wanted to determine if there were cancer of the body. We would curette the uterus and have the scrapings examined under the microscope. We could then differentiate between a malignant growth and an endometritis. If we do not find evidences of endometritis or of carcinoma, we can decide if it be a polyp by passing the finger into the uterus and simply feeling the growth, first, if necessary, dilating the cervix. This exploration of the interior of the uterus is too important to be neglected in doubtful cases. This woman has a fibroid. I want to determine if she can bear an operation. She is still flowing, which renders her rather anemic. She is weak; gets out of breath easily; her pulse is rapid, about 90; it sometimes drops to 80 or less, and then again rises to 90 or more. Another point of importance to be considered in deciding the question of operation is the condition of the urine. When she came here the amount was small, of low specific gravity, 1014, and contained traces of albumin, a few leucocytes, blood-cells, and epithelial cells. The albumin and the small quantity of urine secreted made us think it best to treat her for a while preparatory to giving her an anesthetic. With albumin in the urine, it is necessary before a long operation to get the kidneys into a healthy condition. Hence she has been given the treatment usual in such cases, daily hot-air baths, alkalies, and plenty of water to drink, combined with tonics. In two weeks her urinary secretion has increased markedly in amount; its specific gravity is higher, 1020; the albumin is diminished, although there is still a faint trace of it; her heart is better, and her gen-

eral health is improved; so I think I can safely operate in a few days.

The patient, being fifty-five years old, should have had the change of life some time since, but, as is so often the case in women with fibroids, it has held off. If it should come, she might be relieved of all her symptoms without operation. She is anxious to have an operation and I shall do a hysterectomy, operating through the abdomen, as the tumor is too large to take out easily by the vagina. The results in these cases are almost always satisfactory. In this case I think the patient will have the best chance if we anesthetize her with chloroform. Very likely I shall decide to begin with ether and to continue the anesthetization after a few minutes, with chloroform. Most of the deaths from chloroform occur in the stage of excitement during the first two or three minutes; and the injury to the kidneys from ether comes from its long-continued use. Thus both risks are diminished by giving the ether for a short time first, and then going on with chloroform.¹

Enteroptosis; Retroversion; Ruptured Perineum.—The second patient is forty years old, and the mother of five children, having also had three miscarriages. The forceps have always been used at the birth of her children. She has been ill for the last two years. Her principal symptoms are dragging and bearing-down pains, pain across the back, and in the top of her head. She is dizzy at times and sometimes falls down unconscious. She is troubled with palpitation. Her monthly periods have been disturbed for the last two years. They are anticipated each time by a slight flow, which lasts four or five days. Four months ago the flow lasted a month. It has never been excessive in amount, rather scanty than otherwise, but has increased during her illness. Her digestion is faulty, and for the last four weeks has been worse.

A careful examination of the abdomen reveals quite a serious state of affairs. There is a general falling-down of all the abdominal viscera. The kidney on the right side is loose, falling almost to the pelvis, and is very tender. The transverse colon is greatly prolapsed. It is very commonly displaced. I find it below the umbilicus in probably fifty per cent. of the cases upon which I perform abdominal section. The vaginal examination also shows various affections of the pelvis viscera. I find a ruptured perineum, a badly lacerated cervix, retroversion of the uterus, with induration and hardening around the cervix due to the laceration. It is difficult to say what was the starting-point of the patient's troubles, but they probably followed confinement and the lacerations. The heart symptoms, the digestive disorder, etc., are all functional. There is no organic trouble with the heart; the pulse is good. There is a great quantity of pus in her urine, although the amount of urine is fair, and the specific gravity about normal. There

is a faint trace of albumin so I shall have her anesthetized with chloroform instead of ether.

I propose this morning to curette the uterus, close the perineum, and repair the cervix, and perhaps do Alexander's operation. It is possible I may fasten up the displaced kidney.¹ In one case I did seven operations at one sitting; I curetted the uterus, closed the cervix, sewed up the anterior vaginal wall, repaired the perineum, opened the abdomen, removed a fibroid growth, and sewed the uterus up to the anterior abdominal wall. To have done one operation at a time and waited for the patient to get well before doing the next, would have kept her in the hospital five or six months. As it was, she was out in less than a month. The sewing-up of the kidney is not, of course, a strictly gynecological operation, but, as it was largely advocated by the gynecological surgeons, it has come to be considered a part of their work.

MEDICAL PROGRESS.

Sympathetic Ophthalmia.—Gifford (*Annals of Ophthal.*, Vol. IX., No. 1) relates the histories of two cases of sympathetic inflammation following a perforating injury in the first eye, and one mild case following a cataract extraction. By medicinal treatment, together with enucleation of the injured eye, he was successful in retaining useful vision in the sympathizing eye in all the cases. In all there was an absence of the premonitory symptoms, such as photophobia, ciliary injection and asthenopia, which, according to the text-books, are warnings of danger. In fact, these signs of sympathetic irritation are rarely followed by true inflammation. In the three cases reported the uninjured eye felt perfectly well up to the time when the appearance of inflammatory products showed that the inflammation was present and under way to such an extent that even enucleation of the injured eye did not stay its progress. A point of the utmost importance for the early recognition of the disease, particularly when the patient is not under the constant observation of an ophthalmologist, is the performance daily of tests of the acuteness of vision. Gifford has treated earlier cases with atropine, hot applications and mercurial inunctions, in the usual way, without perceptible benefit. The later cases were treated with salicylate of soda, which in one instance was increased to 180 grains in the twenty-four hours. The results obtained by this treatment were very good. It is still an open question whether the inflammation reaches the second eye through the medium of the optic-nerve trunk and chiasm, as first suggested by Arlt, or possibly by Mackenzie, whose expression on this point was ambiguous; or through the intervaginal and subdural spaces, as suggested by Leber and Deutschmann; or along the vessels

¹ This patient was operated on successfully, and returned to her home in three and one-half weeks.

¹ Operations on the endometrium, the anterior vaginal wall, cervix, perineum, kidney and round ligaments were done at one sitting, with perfect recovery.

penetrating the eye and passing through the orbit to the cranial cavity, as first suggested by Gifford, and later by Gaguet; or through the general circulation, as suggested by Berlin.

Intubation of the Larynx.—In a series of seventy-five cases of laryngeal stenosis, in which he has employed the operation of intubation of the larynx, J. W. West (*Am. Gyn. and Obstet. Jour.*, April, 1900) has had a mortality of 43½ per cent., thirty-four of the seventy-five cases having died. The ages of the cases ranged from four months to sixty-two years. He presents a table showing the ages of the cases, the number at each age, and the mortality at each age. Out of five cases under two years of age, three recovered. In thirteen cases seven years old only five cases recovered, but of the eight which died, one died from an organic heart lesion, and two from profound diphtheritic poisoning. In the two last cases the intubation was done simply to relieve the dyspnea during the few hours of life which remained. In one case the obstruction causing the dyspnea was due to erysipelas. In two cases the dyspnea was due to laryngitis following an acute attack of measles, and the other seventy-three were cases of laryngeal diphtheria. Of the two cases following measles, one died. In the one which recovered it was found necessary to wear the tube for two weeks. The youngest patients to recover were two, each thirteen months old, and one fourteen months. The writer presents brief notes of three of the cases, and without describing the technic of the operation, emphasizes the fact that the manipulation must be done as quickly as possible, and that the erect position of the patient is most favorable to a rapid introduction of the tube. Care must be taken not to bruise or wound any of the tissues during the operation. The average time of leaving the tube in position in the cases that recovered was six days. When the dyspnea occurs at or near the onset of the disease it is usually necessary to keep the tube in position longer than in cases in which it occurs later. Intubation should be resorted to without delay when antitoxin and other remedies have failed to bring about speedy relief from dyspnea.

Treatment of Gonorrheal Epididymitis.—A. Spiegelhauer *Monatshft. f. prak. Dermatolog.*, April 15, 1900) applies hot aluminum-acetate solution three times daily to the testicle which he supports by means of a firmly-fitting suspensory. The internal treatment consists in the use of sodium salicylate. This method is said to yield much better results than the time-honored cold applications.

Thoracentesis.—The time for removing the fluid from the chest in pleurisy with effusion depends more on the condition of the circulation and respiration than on the physical signs, says H. Desplato (*Jour. des Sc. méd. de Lille*, April 7, 1900). During the first two or three weeks tapping should be avoided unless the fluid accumulates rapidly, or the patient has attacks of dys-

pnea without apparent cause, or is short of breath on exertion. If the fluid has ceased to accumulate, draw off a part or all and use active purgation, and the disease will be much shortened. The liquid should be withdrawn slowly to allow time for the lung to unfold itself and for the other organs to accommodate themselves to the changed intrathoracic pressure. Accidents are due either to passing the trocar into lung, liver, a tumor, etc., a mishap which should easily be avoided, or to the diminution of the intrathoracic tension, causing cough, albuminous expectoration, hemoptysis, pain and dyspnea. The object of thoracentesis is to permit the lung to expand. If the lung is bound down by adhesions, or is the seat of a pneumonia, or a tuberculous infiltration or a tumor, if it contains cavities, or is emphysematous, or for any other reason has lost its elasticity, it cannot expand, and the negative pressure only serves to increase the difficulty of respiration. Not more than 1200 c.c. should be removed at one time; this is always enough to relieve the urgent symptoms and often allows the rest of the fluid to be rapidly absorbed. If necessary the tapping may be repeated in two or three days. A valuable adjunct to the thoracentesis is massage of the thorax, as this promotes the blood and lymph circulation and stirs up reactionary phenomena in the pleura. Electricity also by acting on the muscles of the region tends to produce the same results.

Acute Gonorrhea.—Purulent discharges from the urethra in typhoid fever, the secondary stage of syphilis, and as a result of irritation, are met with, but the usual cause of urethritis is undoubtedly the gonococcus of Neisser. The earliest symptoms, according to A. E. Garrow (*Montreal Med. Jour.*, March, 1900), are heat and itching in the glans, tickling and subsequent swelling at the meatus, increased tension in the penis, frequent micturition, ardor urinae, and a thin, greyish, watery discharge. Loss of appetite, general malaise, and a haggard appearance depend on the character of the nights. A seldom diagnosed, but not uncommon complication, is spermatoecystitis which is manifested by stabbing pain in the perineum, worse on urinating or defecating and radiating to anal and crural regions; rectal examination reveals a tender, nodular, sausage-shaped mass extending upward from the prostate and best outlined when the bladder is full. The treatment of this condition is to empty the seminal vesicles by pressure or massage, irrigate the posterior urethra and bladder, and treat otherwise as for acute prostatitis. For acute gonorrhea use hot irrigations of large quantities of bichloride or potassium permanganate solution, and follow by an injection of one-half to two per cent. protargol which is retained fifteen to thirty minutes. Irrigate twice daily during the first few days, then once a day. Internally, salol, ten grains three times a day, with cubebs, alkaline diuretics, anodynes and arterial sedatives. When the morning drop or gonor-

rheal threads persist, pencil with silver nitrate and apply 25 to 40 per cent. boroglyceride. For posterior acute urethritis order rest in bed, hot hip-baths and hot irrigations, have patient urinate with penis in hot water, and give injections of protargol once a day. Salol and Dover's powder relieve vesical tenesmus and an opium suppository or morphine may be required to secure rest at night.

After-Treatment of Peritoneal Section.—Henry T. Byford (*Am. Gyn. and Obstet. Jour.*, April, 1900) employs the following treatment after all cases of peritoneal section. The object of the treatment is to systematically induce peristaltic action as soon as possible after a peritoneal section for the purpose of preventing intestinal paralysis and adhesions. The treatment is begun by giving the patient four drams of fluid extract of cascara, or some equivalent, two hours before the operation. In those cases in which adhesions were separated and raw surfaces left, a high glycerin enema is given before the patient is taken from the table. In all cases dram doses of sulphate of magnesia are given every hour from the time the patient awakes after the operation, and a high glycerin and water enema—two to four ounces—every two hours, beginning eight hours after. This treatment must not be discontinued until the patient passes flatus not only with the enemas but also freely between enemas. In order to maintain frequent peristalsis and a daily evacuation of the bowels after the first days, the writer gives two drams of sulphate of magnesia or two or three ounces of Hunyadi water every night and morning for two weeks, regulating the size of the doses according to their effect. The treatment is sometimes modified, if the patient needs a stimulant, by adding an ounce of whiskey to the enema given on the operating-table; if much blood has been lost, a high beef tea enema is given instead and is repeated every four hours. Strong beef tea enemata usually cause vigorous peristalsis within twenty-four hours. Instead of the sulphate of magnesia small doses of Hunyadi water or liquid citrate of magnesia, or of the granular citrate may be given. Instead of the cascara, the writer often gives syrup of figs and when the glycerin does not act well, ox-gall enemata are substituted. As the result of this treatment Byford finds that there are practically no temperature cases, no crying for morphine, no bloating, no fixed pains, and seldom any subsequent pain in the ovarian region even when adherent appendages have been removed. The convalescence is more rapid and the patient more comfortable during it. In the simpler cases of peritoneal section treated in this manner the patient can, without harm, if the abdominal wound is entirely healed and well supported, get out of bed in ten or twelve days.

Spastic Esophageal Closure in Urinary Intoxication.—In cases of intoxication by means of retained urine, it often happens that disorders of the digestive system arise re-

sulting therefrom. These disorders are usually the accompaniment of the chronic form of retention. S. Groszlik of Warsaw reports an interesting case in point. (*Centralbl. f. d. Krankh. d. Harn und Sexual-Org.*, B. xi. Heft. 2), in which specialists on internal diseases had made incorrect diagnoses of carcinoma of the stomach or intestine—such diagnoses depending upon the extreme emaciation and cachexia present. All kinds of internal medication consistent with the incorrect diagnosis were tried, but uniformly without success in such cases. The symptoms most striking are esophageal disorders, vomiting and diarrhea, and the combination of all three very soon conduce to the patient's extreme decline and emaciation. But the most important factor in this cachexia is the difficulty in swallowing solid food—the most distressing of all symptoms for the patient. French literature aptly terms this general condition as "*grande dyspepsie urinaire*." The cause of this difficulty in swallowing is the marked dryness of the buccal cavity due to diminished glandular activity, hence the term "*dysphagie buccale*." In his own case, Groszlik found the localization to be in the lower segment of the esophagus, which had led others to make the diagnosis of esophageal carcinoma. The condition was one that followed poor catheterization of the bladder, the symptoms of stenosis coming on very quickly thereafter. This rapidity of onset, determined Groszlik, could hardly have been due to carcinoma; and the combination of symptoms, seemingly uremic, suggested to him the possibility of a urinary cachexia rather than a carcinomatous one. Daily irrigations of the bladder with nitrate of silver, 1-2000, together with tentative feeding of fluids by mouth and rectal alimentation brought the patient around within two weeks. At the end of that time not only fluids, but soft diet could easily be administered per os and the patient began to nourish himself. The septic condition of the urine also constantly diminished until within twenty days the patient was discharged cured. The case proved interesting from the fact that it was the first one in which a spastic stenosis of the esophagus had been seen depending upon urinary intoxication. Internal medication is absolutely nugatory in such cases. The fact that the spasm lasted for so long a time and disappeared synchronously with the clearing of the urine proves that it was not a spontaneous closure, but one dependent upon urinary infection.

Meteorism in Typhoid.—W. E. Tschernow, (*Klin. therap. Woch.*, April 22, 1900) has obtained gratifying results from the local use of ice in combating tympanites in typhoid. The abnormal distention being due to excessive gas-formation and to paresis of the neuromotor apparatus of the intestine, owing to the infiltration of its walls with the product of abnormal fermentation, it follows that in case of diarrhea intestinal antiseptics would also be indicated. The author has found these drugs of good service.

and, contrary to recent experimental evidence, thinks they are well able to interfere with excessive putrefaction. In case of tympanites with constipation in typhoid, he recommends enemata of turpentine or asafetida, and advises direct puncture of the gut when the meteorism is so marked as to interfere with heart and lungs.

Secondary Suture of Brachial Plexus.—W. Thorburn (*Brit. Med. Jour.*, May 5, 1900) publishes a unique case of suture of the brachial plexus seven and one-half months after its traumatic rupture. There was complete paralysis and anesthesia of the limb with marked trophic changes. There was sufficient evidence to show that the nerves were not torn from the cord. At the time of operation the cicatrix between the ruptured ends was excised, and the various nerve-trunks sutured as nearly as possible in their old relations. After six and one-half months, without special treatment, the various functions began to reappear and have improved moderately up to the present time, four years after operation. This proves that the plexus is capable of repair after complete resection. The case would have shown more improvement with systematic massage and attention. This is the first reported case of suture so long after the primary injury. Its comparative success holds out hope for many limbs which would otherwise be condemned to amputation as useless encumbrances. In cases in which the nerves are torn from the cord operation is hopeless.

Ethyl Chloride as an Anesthetic.—To the general rule that no anesthetic is absolutely safe, ethyl chloride makes no exception, according to G. Lotheisen (*Munch. med. Woch.*, May 1, 1900). Opisthotonos, great excitation, cyanosis and asphyxia have followed its use. On the whole, however, the author's results were satisfying, in that the mortality did not exceed that of chloroform and, he thinks, with greater experience can be still further reduced. The stage of anesthesia is rapidly reached, recovery is prompt and kidneys, heart or lungs do not seem to suffer. In case of alcoholics it is good to precede the inhalations with an injection of heroin. During protracted operations, vomiting occasionally occurs, but is never so severe as with ether or chloroform. Narcosis should invariably be begun with small amounts and as soon as the slightest degree of cyanosis or excitement appears, the inhaler should be removed and the face vigorously rubbed with a cold towel.

Vasectomy.—R. Harrison (*Lancet*, May 5, 1900) says that vasectomy usually causes shrinkage of the prostate, except when carcinomatous, adenomatous or fibroid changes exist. The operation itself is slight and does no harm even in those cases in which little good seems to result. After following a number of cases for some time, he was able to demonstrate that the usual effect of vasectomy is shrinkage of the prostate; that although this shrinkage affords readier access to

the bladder, it does not necessarily restore natural micturition, this failure being due to structural bladder changes resulting from the long-continued obstruction; these changes consist of varying grades of sacculation and trabeculation permanently damaging the vesical expulsive power. It is a most interesting fact that a comparatively small sacculation can throw the whole expulsive mechanism out of gear. Therefore, when vasectomy fails to give the desired relief one must look to structural bladder changes and, since these are the result of prolonged obstruction, the natural indication would be to shrink the prostate soon after the onset of obstructive symptoms. The best results of vasectomy have been obtained in cases on the border-line of the development of these structural changes, which continued catheterization does not remove. Vasectomy does not destroy sexual power as does castration; it is most useful in the earlier stages of prostatic hypertrophy; it is not useful in cases of fibroid degeneration or malignant change; it renders catheterism easier where changes in the bladder render normal micturition impossible even after prostatic shrinkage.

The Therapeutic Value of Iodipin.—All the preparations of iodine heretofore in use have the disadvantage of causing the train of symptoms known collectively as "iodism" before the particular drug administered has had the chance to be therapeutically effective. The cause of these symptoms may be ascribed to the rapid separation of free iodine from its compounds, notably the potassium iodide, and to its attacking the mucous membranes of the stomach and intestinal tract. J. W. Frieser (*Wiener klin. Rundschau*, April 22, 1900) describes his experience with a new iodine preparation, originally used by H. Winternitz and called "iodipin," which has none of the above mentioned disagreeable effects. This drug is manufactured by E. Merk in Darmstadt. In Frieser's practice, the result of its use was always a good one; it could be depended upon; it was better borne by the patient and decidedly more acceptable to him than potassium iodide; iodism or gastric disturbances could never be shown as a concomitant. When the patients objected to take iodipin on account of its oily taste, it was given subcutaneously or per rectum. Especially in lues was the result of iodipin noteworthy, in many cases being better even than the mercurials. These good results obtained by the use of iodipin are to be accredited to the fact of its slow decomposition within the body, the iodine being given off in all probability in the blood itself and that only gradually. This insures the gastro-intestinal tract against the malign influences of the free iodine and for that reason iodipin may be administered for a prolonged time without bad constitutional effect. The fact that iodipin circulates in the body-fluids and thereby becomes deposited in the various organs allows the freed iodine to act directly upon the cell and effect its economy. Frieser demonstrated the presence of iodine in

urine and saliva fifteen minutes after its administration per os, while after subcutaneous use it required three and four days to be detected in the same secretions. In the feces iodine was scarcely ever present. Iodipin, which is prepared from iodine and oil of sesame is to be obtained in ten and twenty-five per cent. strength. Its composition is based upon the well-known fact of the affinity of the halogens for fats. In appearance and taste it resembles oil of sesame. It is extremely stable, even months elapsing before decomposition sets in. The dose internally is two to three drams of the ten-per-cent. preparation, while per rectum as much as five to seven ounces may be given in clysms. The twenty-five-per-cent. iodipin is used exclusively for subcutaneous injection. The drug is to be given about two weeks at a time and its oily taste may best be disguised with ol. menthae, syrup. cort, aurant. or other aromatics. For subcutaneous injection, about ten cubic centimeters are used in the gluteal region or the back. A needle of slightly larger caliber than usual is advantageous for this purpose. In order that the twenty-five-per-cent. iodipin may become less dense it is frequently warmed before using it by placing the bottle containing it in warm water. Besides using iodipin in syphilitic cases, the author has had much success with it in emphysema and asthma. Bearing in mind all the advantages of iodipin over potassium and other iodides, we are forced to consider the advent of this new preparation with the greatest favor.

Typhoid Infection without Intestinal Lesions. W. Ophüls (*N. Y. Med. Jour.*, May 12, 1900) reports another case of typhoid fever giving a positive Widal reaction in which no intestinal lesions were found at autopsy. The clinical symptoms were typical and unmistakable, the patient dying eight days after admission to the hospital in San Francisco. Thirteen cases have previously been reported, and these have been considered as proving that there are forms of typhoid infection with unusual primary localization of the virus. The author, however, believes that in his own case, as well as in several others reported previously, the organisms really came from the intestines and that the absence of anatomical lesions does not disprove this opinion. He reviews the cases showing that in many instances death came late in the disease, often as a result of a complication, and ample time had elapsed for complete recovery from any intestinal lesion. In his own case swelling and hyperplasia of the lymphatic mesentery-glands especially point to this fact.

Treatment of Hay-Fever by Suprarenal Gland.—The most constant clinical lesion of hay-fever is a nasal vasomotor paralysis with an accompanying congestion and edema, producing characteristic symptoms which are, however, never more than those of an acute inflammation of the respiratory mucous membrane. The accompanying local lesion and psychological factor which

are supposed to complete the chain may be wanting. B. Douglas (*N. Y. Med. Jour.*, May 12, 1900) points out the peculiar antagonism which the action of suprarenal gland bears to the clinical symptoms of hay-fever and reviews the limited literature upon the subject. After considerable experience with the drug, he believes that no other remedy has such prompt and decided action. It may be given either internally or locally with the same result and has the enormous advantage over the ordinary remedies in leaving no after-effect. When used for a long time, both locally and internally, it may cause such a constant diminution in the nutrition of the parts that atrophy may result. Its best result is achieved in the simple cases in which the principal symptoms are those of a nasal and pharyngeal inflammation. The asthmatic tendency may be diminished, but where the asthma has already developed the drug seems to have very little effect. A combination of internal and local treatment seems to be best. A solution of six or twelve per cent. is made by shaking up the saccharated dried extract with water and decanting after one hour. This may be applied by spray every two hours till the symptoms are controlled. Internally, five-grain tablets may be administered every two hours at first, day and night, until giddiness or palpitation is observed or until the vasomotor paralysis is controlled. The dose may then be given at gradually increasing intervals. The author believes the drug to be almost a specific, but recommends the use also of other recognized adjuvants, such as digitalis, quinine, cocaine, and Clark's solution.

Premature Babies.—The clinical picture of these is characteristic, says J. D. Voorhees (*Archives of Pediatrics*, May, 1900). The head is large in proportion, the abdomen prominent, the face thin and peaked, the body jaundiced, covered with lanugo, the skin soft and delicate, wrinkled in some places or so thin that the veins shine through. The movements are very weak, the respirations irregular and superficial, and often suspended for a time. For treatment the essentials are to maintain a proper temperature, to give the proper amount and kind of nourishment, to avoid infection, and to prevent exhaustion. Without harsh methods of resuscitation, but by hot baths or light titillation, the baby is made to cry lustily, the cord tied off, its body anointed with albolene, and it is dressed, not with cotton which makes it perspire, but with a light shirt, and a napkin which is pinned over the feet and legs. It is then, without being bathed, placed in an incubator at 86° to 92° F., or kept in a properly-warmed room. Six hours after birth half to one teaspoonful of warm five- to six-per-cent. sugar-of-milk solution is given and repeated each hour. After twenty-four to thirty-six hours an equal part of breast-milk is added, not, however, from the mother's breast, but from a wet-nurse seven or eight days postpartum. The amount is increased one dram at a time until at the end of a

week the child it taking six or eight drams each hour. If the stools are normal, increase the breast-milk and diminish the sugar solution. The food may have to be given with a dropper, but generally the child will suck a small nipple. Occasionally gavage is necessary. After a week or two the child may be tried at the mother's breast two or three times a day, and, if it does well, every two hours. These babies are liable to cyanosis and require slapping or the administration of oxygen during the attack, and a few drops of brandy in hot water every two or three hours. Always first ascertain, however, that nothing has been aspirated into the larynx. The weak lungs and gastro-enteric tract make these babies especially susceptible to infections, and to the irritation of dirt in nose, mouth, eyes, and on the skin. The babies require to have napkins changed about four times a day. They gain weight slowly, and are doing unusually well if they reach their birth-weight at the end of two or three weeks.

Postdiphtheritic Laryngeal Stenosis.—J. Rogers, Jr., (*Annals of Surgery*, May, 1900) says that for years the treatment of laryngeal stenosis following diphtheria has been most difficult and unsatisfactory. Various operative procedures have been resorted to in vain. These operations were done under the belief that the stenosis was due to exuberant granulations, or to a contracting cicatrix following ulceration. As a matter of fact, the stenosis is due to subglottic hypertrophic laryngitis, which sufficiently explains the failure of the ordinary operative procedures. The author has cured several long-standing cases by inserting as large a tube as the larynx will admit without being lacerated and leaving it in place for from two to three months, removing it perhaps once for cleansing purposes. The tube must be of hard rubber, as the metal tubes become incrustated and cause ulceration.

Pleurisy Complicating Appendicitis.—From the consideration of a number of cases, M. Dieulafoy (*Bull. de l'Acad. de Méd.*, April 16, 1900) draws the following conclusions: There is an appendicular pleurisy as there is an appendicular liver, the former, however, being propagated by adhesions and lymphatics, the latter by the portal circulation. The pleurisy is found especially in recurrent appendicitis and usually occurs a few days after the onset of the abdominal symptoms, when the latter have begun to subside. The infection passes up behind the cecum and colon, its passage being marked by pus, adhesions, and at times encysted collections; the infectious products may penetrate the liver, or form a subphrenic abscess. They reach the pleura by perforating the diaphragm or by means of the lymphatics. Appendicular pleurisy is almost always right-sided, and may be confused with hepatic or subdiaphragmatic abscess. There are sharp pains in the right hypochondriac region and thorax, radiating toward the shoulder, a dry cough and intense dyspnea. Sometimes it is a

dry pleurisy, sometimes an ordinary pleurisy with effusion, the infection being reduced to a minimum; but in most cases it is an empyema with a turbid, fetid and putrid collection. Auscultation and percussion give signs of great effusion, with sometimes evidence of pneumothorax due to the disengagement of gas by putrefactive bacteria. The prognosis is serious, depending upon the general condition, the state of the pulse, and the degree of enfeeblement. A fetid and putrid right pleurisy should always lead to an inquiry about appendicular signs in the preceding week or two. Surgical intervention should be prompt, and it may be necessary to operate for the appendicitis as well as for the empyema. The proper treatment is, however, prophylactic, and to this end the appendix should be removed in all cases of appendicitis, so that the numberless dangers and complications of this affection may be prevented.

Enteroptosis.—The cases of enteroptosis, writes Hector Maillart (*Revue méd. de la Suisse Romande*, April 20, 1900), may be divided into two groups, *viz.*: The hereditary, appearing in youth and producing permanent invalidism or rebellious neurasthenia, with persistently recurring stomach derangements, constipation, and headache; and the acquired, evidently due to purely mechanical conditions, usually beginning later in life and easily diagnosed. Every physician knows that phthisis and cardiac disease are unfavorably influenced by pregnancy, but it is not well known that pregnancy may produce a temporary, and even a permanent, cure of enteroptosis. The enlarging uterus increases the intra-abdominal tension, and at the same time pushes back into place the organs which have fallen by gravity. The digestive functions improve, the neurotic condition disappears, and the patients gain flesh and vigor. After childbirth, when up and about, a binder should be applied over the lower part of the abdomen, and it should be made broader than below so as to support the abdomen without compressing it. The wearing of corsets must be avoided, and the weight of skirts should be borne by the shoulders.

Treatment of Muscular Rheumatism.—In alleviating the sufferings of both acute and chronic muscular rheumatism the physician is often handicapped by want of proper appliances to carry out the more extensive hydrotherapeutic measures, while, on the other hand, internal medication too often fails to allow him to dispense with the former. In injections of sodium iodate, S. Otto (*Therap. Monatshft.*, April, 1900) has found a simple procedure well able to replace the more elaborate ones. A single injection of 7.5 to 15 grains is usually followed by prompt relief. The drug should be introduced at the site of pain in the form of a five-per-cent. solution. Great care should be taken to have both salt and solution as fresh as possible, since the presence of free iodine causes much irritation.

THE MEDICAL NEWS.

A WEEKLY JOURNAL
OF MEDICAL SCIENCE.

COMMUNICATIONS in the form of Scientific Articles, Clinical Memoranda, Correspondence, or News Items of interest to the profession are invited from all parts of the world. Reprints to the number of 250 of original articles contributed exclusively to the MEDICAL NEWS will be furnished without charge if the request therefor accompanies the manuscript. When necessary to elucidate the text illustrations will be engraved from drawings or photographs furnished by the author. Manuscript should be typewritten.

J. RIDDLE GOFFE, Ph.M., M.D., Editor,
No. 111 FIFTH AVENUE, NEW YORK.

Subscription Price, including postage in U.S. and Canada.

PER ANNUM IN ADVANCE	\$4.00
SINGLE COPIES10
WITH THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES, PER ANNUM	7.50

Subscriptions may begin at any date. The safest mode of remittance is by bank check or postal money order, drawn to the order of the undersigned. When neither is accessible, remittances may be made, at the risk of the publishers, by forwarding in registered letters.

LEA BROTHERS & CO.,
No. 111 FIFTH AVENUE (corner of 18th St.), NEW YORK,
AND NOS. 705, 708, & 710 SANSON ST., PHILADELPHIA.

SATURDAY, MAY 19, 1900.

THE STAMPING-OUT OF SCIENTIFIC ADVANCE IN PSYCHIATRY.

THE progress of scientific research in psychiatry seems to be extremely diverse and tortuous. No sooner is an institution organized and making progress in the line of psychiatric research than a heavy iron hand is put on its very heartstrings with the intent to crush out its activity and life. Far be it from us to accuse the psychiatric profession as a whole of this terrible, if not criminal, work of oppression and suppression of scientific progress. No profession is as eager as the psychiatric to welcome scientific enquiry, but those who interfere with or arrest psychiatric research are not sufficiently stigmatized and branded by their psychiatric brethren. Whether this mercy to those who deliberately crush science is due to the lack of strength of collective professional opinion, or to the lenient spirit acquired by long experience in an atmosphere of intellectual bizarreness and moral aberration, it is certainly hard to tell. One thing is sure that such a state of things is extremely unfortunate and greatly to be regretted. Still more is it to be regretted when attacks in scientific research are committed by a man who, if he is not, still claims to be the

chief and leader of the psychiatric profession in the United States.

As an illustration may be taken the present condition of the Pathological Institute of the New York State Hospitals. The psychiatric profession has put its hopes on the Pathological Institute, and not without reason. In this country and abroad the work of the Institute is hailed with delight. Important guiding principles for the work were laid out by the Director; methods for psychiatry were being elaborated by its staff of scientists and work of high scientific merit were being conducted and being depicted in the Archives; the Institute as a whole was fairly under way, when suddenly the Commission in Lunacy, of which Dr. Peter Wise is the President, bethought itself of the expediency of arresting the scientific work of the Institute, claiming its work to be "improper" and, to abet and assist in this destructive work, calling upon a committee of men that are unfit to judge of the scientific work of the Institute. Two of the committee are asylum-men, while the third is a pathologist who has no reputation as a psychiatrist or as a neuropathologist. This committee openly repudiates scientific work in psychiatry carried on by the Pathological Institute, thus attempting to arrest the progress of psychiatric science, and degrading it to a condition occupied a quarter of a century ago. We hope that the psychiatric profession, and particularly the American Medico-Psychological Association guarding its interests, will be aroused to indignation over the outrage committed on a scientific psychiatric institute by a committee of men who could not or would not regard the vital importance of research work in the science of psychiatry.

THE TENEMENT-HOUSE COMMISSION AND ITS WORK.

THE problem before the admirable Tenement-House Commission, whose appointment and personnel we referred to last week, is a serious and important one. As Governor Roosevelt well said, "It is second in vital interest to no other, not even that of the City Charter." By one of the ironies of fate, the Queen City of the newest of the great nations contains some of the most crowded areas that are to be found in the civilized world. The figures are simply appalling. According to *Charities*, the official organ of the Charity Organization, not a few single blocks, in the city, house and shelter a seething popula-

tion of fully 2000 inhabitants, and one of them, between Sixty-first and Sixty-second Streets and Tenth Avenue, reaches the deadly climax of 3978 persons. Even at the former rate this would work out a population of over 400,000 per square mile, and Mr. William Potts declares that certain areas in the city actually now contain over 1000 persons per acre—nearly double the density to be found anywhere else in the world. As this leaves barely forty square feet of service for each individual, little more than the historic six feet of English soil promised the Danish invader by the last of the Saxon kings, it needs no exercise of the imagination to conceive how not merely health, but the plainest decency, must be literally suffocated out of existence under such fearful pressure. Nor can we console ourselves with the thought that this condition is largely a heritage of the past, with its lack of legal control and its inability to conceive of the enormous rapidity of the city's growth, for, while Five Points has been wiped out and Mulberry Bend reformed, some of the worst instances of congestion are to be found in comparatively new regions of the city and in modern tenements. Indeed, many of the workers in the cause of tenement-reform declare the new sky-scraper, in spite of its imposing appearance, worse from a hygienic standpoint than the old barracks. Every room, it is true, is supposed to have its window, but when these windows open upon an air-shaft, two and a half feet wide and sixty feet in depth, their value as a source of either light or air can well be imagined. The air-shafts are far more effective as disseminators of foul smells and as huge flues, up which in case of fire the flames travel with incredible speed to every floor, than as ventilators.

Then, again, while every foot of space even in the darkest inside rooms of the old barracks was occupied they were only three or at least four stories high, and the actual number of people which they could pile upon a given ground area was less than that accommodated by the huge, high, modern building. It has come not to be a question of cubic space in bed-rooms and living-rooms, but of ground breathing-space and elbow-room, for in many of these neighborhoods the street is the only play-ground, and when six layers of budding humanity come to be discharged into them every morning, the situation becomes a serious one from this point of view alone. And as these tall insanitary types of buildings, relying upon the delusive air-shafts as a source of light

and air, are being built at the rate of two thousand a year, it is high time that action of some sort be taken and the Commission has been appointed none too soon.

Although rapid transit has accomplished much in scattering the crowded thousands of workers over wider areas, the shape and surroundings of Manhattan Island are so unfortunate, from this point of view, and the population is increasing so rapidly that little permanent relief can be hoped for from this source, especially in the lower districts, and the battle must be fought out in the tenements themselves.

No member of our profession needs to be reminded of the relation of overcrowding and disease. Years ago the authorities of Berlin began collecting facts with tireless Teutonic patience and were able to show that nearly half the death-rate of the city occurred in families living in single rooms, although they constituted about one-eighteenth of the entire population. Their mortality-rate reached the astonishing pitch of 163.5 per 1000 per annum, more than eight times the normal city rate. Among families living in two rooms the rate fell to 22.5 per 1000 and to as low a figure as 7.5 in families occupying three or more rooms.

At the late International Congress upon Tuberculosis in Berlin, carefully-prepared studies showed that England headed the roll of honor among the nations and London among the cities with the lowest death-rate from tuberculosis. This was attributed chiefly to the small number of inhabitants per room and per house as compared with the Continental nations and cities, so that the connection between this disease and overcrowding is a close and constant one, as the experience of Naples has also shown. In all the over-crowded blocks alluded to in our opening paragraph the death-rate exceeds the city average in New York by from 10 to 18 per 1000 or from 50 to 85 per cent. Probably few more vivid and impressive demonstrations of this connection have been made than the disease chart of the admirable tenement-house exhibit held at Sherry's old rooms last February. In this the tenements were represented by pink color-blocks, the length of which indicated the proportion of the ground-space occupied, while the incidence of the four chief infectious diseases, tuberculosis, typhoid, scarlet fever and diphtheria, was indicated by variously-colored dots. The blocks and the dots grouped themselves together in the most striking manner. Wherever tenements were more than

three stories high and occupied more than fifty per cent. of light- and air-space, there the dots clustered thickly and, contrary to general impression, as we have already stated, many of the old three-story barrack-areas showed less of both disease and poverty than the modern five and six-story buildings. In one block in Cherry Street fourteen out of the twenty-two houses showed the black dot indicating tuberculosis, and in one of these, No. 144, known to fame as the "Ink-Pot," were no less than seventeen cases of the disease.

The task before the Commission is no light one for the forces which make for the maintenance of the present state of affairs are enormously strong. Chief among these, of course, are the necessities of the tenant and the greed of the speculative builder and landlord. One wonders that the working classes submit to such fearful herding together but, as two-thirds of the population of New York City are compelled to live in tenements of some class, the best that is offered them is a choice of evils. Indeed, the stern necessities of the situation in some cases drive them to actively assist in the overcrowding. The average rent-rate in New York is no less than 24 per cent. of the tenant's earnings, as compared with 12 per cent. in Berlin, and to meet this drain families not only crowd into a disastrously small room-space but take in boarders as well. Especially is this the custom in the Italian tenements, where two or more families will sometimes occupy a single room which is simply packed with bunks and cots. And when these crowded rooms open not upon the street but upon air-shafts, fourteen inches wide and twenty-five feet deep, with thirty-nine windows opening into it, the condition of the atmosphere can be better imagined than described. Yet in these dark dens, worse than the original cave-dwellings of the race, the rents range from ten to seventeen dollars per month for from three to four rooms, the price of an entire house in most suburbs. And such houses as these are actually being erected under the present law, which Commissioner Brady of the Building Department declares to be "all that it need be," and the Tenement Commission, consequently, a complete superfluity.

This dictum, however, will not greatly discourage the newly-appointed body which has practically decided that the facts in the case are already so well known through the work of the Charity Organization Society and of other investigators, including many of the members of the

Commission itself, that they can proceed at once to the consideration of what can be done to remedy the situation by legal measures. The outlook before them, although stormy, is far from discouraging, for the experience of Glasgow, London, Birmingham, and Berlin, has already shown what immense improvements can already be hoped for from judicious regulation seconded by persistent individual effort. How this success has been attained we hope to discuss in a future issue.

ECHOES AND NEWS.

NEW YORK.

New Cure for Diphtheria.—We learn from Santiago de Cuba that leading members of the medical profession report radical cures of diphtheritic cases by the initial application of paraffin.

Emergency Hospitals in Brooklyn.—Charity Commissioner Simis proposes to take a large number of dwelling-houses, scattered in various parts of the borough, and use them as emergency hospitals. They will each accommodate from twenty to thirty patients.

The Harlem Hospital.—Commissioner Keller in a recent address declared that the most glaring need in the Department of Charities is a new hospital in Harlem. The present Harlem Hospital, he said, is a makeshift from top to bottom, a disgrace to the city, and a reproach to the intelligence of the people of New York. The Commissioner also announces his intention of converting the building occupied by the Cornell Medical School in the Bellevue Hospital grounds into a first-class, up-to-date maternity hospital. The Maternity Hospital on Twenty-sixth Street will be occupied as a dormitory for the Bellevue Hospital employees. In the autumn three buildings on Blackwell's Island will be appropriated to the use of segregating tuberculosis patients.

Contagious Diseases.—For the week ending May 12, 1900: Measles, 559 cases and 14 deaths; diphtheria, 288 cases and 44 deaths; laryngeal diphtheria (croup), 9 cases and 7 deaths; scarlet fever, 166 cases and 12 deaths; chicken-pox, 11 cases; tuberculosis, 241 cases and 197 deaths; typhoid fever, 21 cases and 13 deaths; cerebrospinal meningitis, 1 death. Totals, 1295 cases and 288 deaths.

Medical Societies Merged.—At a special meeting of the New York Medical Association, held May 11th, in the New York Academy of Medicine, it was unanimously voted that the County Association should become merged into the New York State Medical Association under its new charter recently obtained at Albany. The action taken was a ratification of the proceedings of the State Association in making all county organizations subordinate associations.

Walter Duryea Able to Write.—Walter Duryea, who sustained a fracture of a cervical vertebra in August last while diving and who was operated on a month later by Dr. Abbe in Roosevelt Hospital, where he has been a private patient ever since, is now able to write. On May 11th he amused himself and delighted his friends and attendants by showing that he had sufficient strength and control of his movements to write his name and several short sentences.

New York State Board of Health.—Dr. Daniel Lewis of this city was reelected President of the State Board of Health at the annual meeting of that body held at Albany, May 11th. Dr. S. Case Jones of Rochester and Dr. Frederick W. Smith of Syracuse were appointed a commission on tuberculosis, and Drs. Lewis, Jenkins and Smelzer were appointed a committee to investigate the best system of disposal plants.

St. John's Guild.—This charity, which cares for thousands of poor and sick children during the summer months, has received two valuable gifts. Mrs. Augustus D. Julliard, whose husband in 1899 presented the Guild with a new floating-hospital, the "Helen G. Julliard," has given to the Guild the sum of \$50,000, the interest on which is to be used to defray the expenses of operating the boat. Another gift is that of Mrs. Frederic Elliott Lewis, who has arranged for the erection of a new cottage-hospital on the grounds at New Dorp. This gift is in memory of her son, Frederic Chandler Lewis. The cottage is to be detached from the other buildings of the group, and is for the care and treatment of infants who are very ill. During 1899 the Guild gave 82,824 days of treatment at a cost of \$57,993.12. The Guild needs \$60,000 for the work this year, as it has largely increased its field of labor.

The March Death-Rate.—There were 7522 deaths in New York City during March; this gives a death-rate of 24.3 per thousand population. The death-rate in Manhattan Borough that month was 24.4; The Bronx, 33.4; Brooklyn, 23.0; Queens, 21.4; and Richmond, 26.4. One-ninth of these deaths were caused by consumption. The State Board of Health has decided to include pulmonary tuberculosis in the list of infectious and contagious diseases, to be thus reported monthly by the health officers of the different municipalities of the State. The State Board expressly declares that in requiring cases of consumption to be reported it by no means desires to have consumptives isolated or to institute a system of inspection. The Board's intention is to secure, if possible, a census of the number of cases actually existing in the State. Such a census being necessary to determine as to the necessity for State care of consumptives and for making some estimate as to the seriousness of the question from a sanitary point of view.

Dedication of Medical Library Building.—The dedication of the new library building of the Medical Society of the County of Kings occurs

on Saturday, May 19, 1900. The new building is an attractive and imposing structure, a cut of which appeared in the MEDICAL NEWS last year. The exercises include addresses by Dr. George M. Gould of Philadelphia, Dr. James R. Chadwick of Boston, and Dr. Abraham Jacobi of New York; also appropriate remarks in transferring and accepting the building by Dr. William Mad-dren, Chairman of the Building Committee, Dr. Frank E. West, Chairman of the Board of Trustees, and Dr. Lewis S. Pilcher, President of the Society.

PHILADELPHIA.

Warned Against the Plague.—The secretary of the State Board of Health has issued a circular warning the public against the bubonic plague and advising vigilant observance of sanitary laws as a preventive. Especial attention is called to the mining villages of the State, their filthy condition rendering them particularly liable to outbreaks.

Health Report.—Deaths for the week ending May 12th were 494, a decrease of 23 from those of the previous week and an increase of 90 over those of the corresponding week of last year. Contagious diseases: Scarlet fever, 70 cases, 6 deaths; diphtheria, 90 cases, 18 deaths; typhoid fever, 60 cases, 15 deaths. Influenza was responsible for 5 deaths, and 2 new cases of cerebrospinal fever were reported.

Associated Health Authorities and Sanitarians of Pennsylvania.—The seventh annual meeting of this Association will be held at Mechanicsburg May 23-25. Discussion on school hygiene will be opened by Miss Dora Keen of this city. Dr. A. C. Abbott, City Bacteriologist, will deliver an address.

Woman's Medical College.—The forty-eighth annual commencement of this College was held May 16th, a class of twenty-four being graduated. A portrait of Dr. Ann Preston, the first woman who held the position of dean of the College, was presented by the alumnae. An address by the Chinese Minister was a feature of the day. A full report of this and of the Alumnae meetings of May 17th and 18th will appear in a future issue of the MEDICAL NEWS.

Pathological Society.—At the stated meeting of May 10th Drs. Shumway and Posey reported a case of sarcoma of the choroid. The points of interest in the case were: The advanced age of the patient, seventy years; the unusual form of the growth, which was of the alveolar type and originated from the proliferation of the lining endothelium of the larger vessels of the choroid; the early appearance of glaucomatous symptoms; marked inflammatory changes in the iris and ciliary body; the probable metastasis to the liver and brain. This was indicated by the sudden death of the patient a short time after enucleation of the eyeball, although no autopsy was obtained. Dr. Simon Flexner exhibited a tumor which had caused death in a patient by blocking

the small intestine just above the ileocecal valve. The tumor was ulcerated and was supposed to be a cancer although no microscopical examination had been made. No macroscopic evidence of metastasis was present.

Jefferson Commencement.—The seventy-fifth annual commencement of Jefferson Medical College was held on Tuesday, May 15th. The President of the Board of Trustees, Hon. Wm. Potter, conferred the degree of M.D. upon the 106 members of the class of 1900. James D. Moffat, D.D., LL.D., President of Washington and Jefferson College, delivered the address. The speaker began with a history of Jefferson College in Canonsburg, under the charter of which the Jefferson Medical College was founded. He does not commend the tendency of young men to enter the profession earlier in life, but argues for maturer years and a more thorough preliminary education.

County Medical Society.—The regular meeting of May 9th was devoted to a discussion on malaria. Dr. W. S. Thayer, of Johns Hopkins University, read a paper upon "The Life History of the Malarial Parasite." The three methods of transmission of the parasite—by the air, by drinking water, and by the bites of insects—were considered, with the conclusion that evidence points strongly to the last. Some facts were given as to the distribution of the Anopheles, the species of mosquito which has been proved to transmit the disease. In the city of Baltimore, where malaria is not found, the Anopheles is not present; but in the suburbs where malaria is present the insect is easily obtained. In a town of North Carolina, which white people had practically left because of malaria, 50 specimens of the Anopheles were obtained in two hours while the Culex was not found. Upon going eight miles into the interior of the country from this town, the Culex was found but the Anopheles was not. This region was also free from malaria. The speaker concluded from these facts, which have been noted in various countries, that, whether or not all cases of malaria can be accounted for by bites of insects, there is no positive evidence in favor of any other method of transmission. Nearly all the cases of spring malaria are considered to be relapses. The most interesting work now to be followed is to determine the type of mosquito present in given localities, the breeding-place of the same, and the best methods of extermination. Very much aid to investigators can be given by country physicians reporting the time of beginning of epidemics, the relation of these to relapses, the relation of the presence of the disease to the different types of mosquitoes, etc. Dr. Alfred Stengel spoke on "The Diagnosis of Malaria." The quartan type is very rare in Philadelphia. He has examined the blood from cases which have been pronounced malarial neuralgia, malarial disease of the eye, malarial lethargy, etc., and has never found the malarial parasite in any of them. In

regard to the statement that the diagnosis of malaria should never be made unless the parasite be found, he believes that the experienced clinician may sometimes do so. The fact that the organism may be present in the internal organs in large numbers and not in the peripheral circulation does not warrant the microscopist in being too absolute in his conclusions. Puncture of the spleen will probably serve to make the diagnosis certain when the parasite is absent from the peripheral circulation. This method has certain risks, however, and is never necessary in the local types of the disease.

County Medical Society.—The meeting of April 25th was devoted to a discussion of medical education and the recent rulings of the Medical Council of Pennsylvania. Dr. Henry Beates, Jr., of the State Board, gave the reasons for the Medical Council insisting upon four years devoted to the exclusive study of medicine as a requirement for candidates for the State license. Dr. W. W. Keen maintained that college graduates should be given credit for their work and admitted to advanced standing in medical schools. The Medical Council is composed of seven members, none of whom are teachers, only three are physicians, and three of the other four are not educators in any sense, the fourth being the Superintendent of Public Instruction. Hence, it is a mistake to have these men supervise the medical education of the commonwealth. In many colleges the graduates are better fitted for the second year of the medical school than are those who take the first year of the medical school without a college course. If four full years are required of college graduates one of three results will follow: (1) Young men will eschew a college course and begin medicine; (2) they will pursue from one to three years at college and then begin medicine; (3) graduates will go to medical schools of other States where they are recognized. Dr. H. C. Wood believes the first year of a medical course should be taken at a medical school instead of at a lay college. It is better to dwarf the college than the medical course. A high college education is not the best thing for a medical man in all instances. President Stahr of Franklin and Marshall College stated that if college graduates were obliged to enter the first year of a medical school instead of to advanced standing with men of their own caliber they would go to other States. If medical schools demand the degree of A.B. for entrance, then literary colleges will acquiesce. President Warfield of Lafayette stated that with the physicians in their faculty and the facilities for dissection which they possess, they can turn out a better product than can medical schools with their first-year work. President Birdsall of Swarthmore stated that their graduates would pass all the examinations of the first year in the medical schools. Dr. S. Weir Mitchell asked if he meant to include anatomy and was answered that it included everything. The medical schools could build their fences and

the college boys would climb over them. Dr. Edmund Holmes, Demonstrator of Anatomy at the University of Pennsylvania, said that college graduates knew more anatomy than did the men who had taken the first year in the medical school. This is due to the fact that the men in small classes at the colleges possess opportunities which he and his small corps of assistants are not able to give at the medical school. The Society passed resolutions demanding that college graduates be given credit by medical schools for the studies of the course which they have already taken.

CHICAGO.

Why Operate and When in Appendicitis.—Dr. J. B. Murphy spoke upon this subject at the April 25th meeting of the Chicago Medical Society. In speaking from a mortality standpoint, he excluded three classes of cases and retained only one. He excluded appendicular colic. He believes there is such a thing, but does not regard it as a surgical lesion. A diagnosis of appendicular colic can be made. He excluded catarrhal appendicitis as it is generally understood, saying it does not materially, if ever, jeopardize life. He excluded partially recurrent appendicitis, not the acute infective variety of the disease, but the mild so-called recurrent form, which may be either a recurrent catarrhal appendicitis, or a recurrent appendicular colic. In the consideration of the subject he included largely the acute infective form of the disease. Surgeons operate to remove an organ which is acutely infected, and in a very large proportion of cases during the first twenty-four hours, this infection is confined to the wall of the appendix. Indeed, he ventures to say that in ninety-nine cases out of a hundred, in the first twenty-four hours, the disease is limited to the wall of the organ. He omits one per cent., because he has in over nine hundred cases seen four cases of primary perforation from fecal concretions, and he is willing to admit that a few more cases than that may have occurred which had advanced beyond the possibility of recognizing that condition at the time operation was undertaken. Let the pathologic process advance to the second twenty-four hours and the condition will vary from an increased quantity of pus or inflammatory debris in the appendix to a completely gangrenous or necrotic appendix, or to perforation of the organ, with a circumscribed or general peritonitis at the end of forty-eight hours. There are cases of appendicitis dying daily. Why are they dying? Not because they are not within the reach of competent surgical treatment. He has noticed that a large percentage of them die in large cities and among popular, very influential people. Why? First, because this important class of people are treated conservatively, and by conservatively he means cowardly, because the medical man is either incompetent of making a diagnosis, which is positive, on which he is willing to risk his reputation; or, secondly, cowardly because the surgeon is not

ready to face the music and take the responsibility of the risk. Surgeons can operate during that time, that is, the first twenty-four hours, with a mortality of two per cent. at the maximum, as he has never seen a death from a case operated upon inside of this period. The mortality in patients that are operated upon on the second, third, fourth, or fifth days is very much more than two per cent. Does the danger of operation increase with time? Yes, very materially, because the pathologic conditions have changed in the abdomen. For what purpose do surgeons operate? To lessen invalidism; to lessen or prevent recurrent attacks.

When should surgeons operate? If the danger increases with time; if the mortality increases with time; if the convalescence increases with the length of time which elapses between the onset of the attack and the time of operation, there is no ground for postponing operation, if it is indicated, beyond the first twenty-four hours. Taking all of the cases, one with another, in fairly competent hands a mortality of two per cent. can be obtained by operative intervention, and the only time it is possible for a surgeon to have this low mortality is inside of the first forty-eight hours. Inside of the first twenty-four hours the chances are much better; the surgeon is much more certain of his ground. Shall the surgeon operate when the case has gone to the third or fourth day? That depends. If the case has advanced to the third or fourth day and there is a circumscribed appendical abscess, with low temperature, the indications are that the virulence of the intoxication is not great. Then the surgeon can with safety wait. Even then, however, the risk is greater in waiting than in operating at that particular time.

GENERAL.

American Therapeutic Society.—The following officers have been elected: President, Horatio C. Wood, of Philadelphia; 1st vice-president, Howard H. Barker, of Washington; 2d vice-president, R. W. Wilcox, of New York; 3d vice-president, E. H. Long, of Buffalo; secretary, Noble P. Barnes, of Washington; recorder, William M. Sprigg, of Washington; treasurer, John S. McLain, of Washington.

The Pure-Food Bill.—The House Committee has submitted a favorable report on the measure now before Congress designed to prevent the adulteration, misbranding, and imitation of beverages, foods, candies, drugs, and condiments, and to regulate interstate commerce in such commodities. The bill, as now worded, creates a chemical bureau in the Agricultural Department whose duty it shall be to inspect food and drug products. It is sincerely to be hoped that this measure may become a law.

The Huxley Memorial Statue.—On April 30th a statue of Huxley was unveiled by H. R. H. the Prince of Wales in the great hall of the Natural

History Museum, South Kensington. The director of the Museum explained that this statue was the expression of admiration not only of the English people, but of the whole civilized world for one who, as discoverer, writer and man, must be reckoned among the greatest figures in the records of our age. Subscriptions have poured in, amounting in all to over \$16,000, from all parts of the world, including every state of Europe, India, the United States, and England's remotest colonies.

The Plague.—There continue to be reports of plague at Hong Kong. In India reports still confirm the increased virulence and steady advance of the epidemic. In Honolulu all quarantine restrictions were abolished on April 30th, the city being pronounced absolutely free and clean from all infection. The plague is reported as spreading along the Red Sea, several cases have appeared at Port Said, and the American Consul General at Cairo cabled to the Secretary of State, May 9th, that the plague had appeared in Alexandria.

The Increase of Smallpox.—According to the latest "Public Health Reports" of the United States Marine Hospital Service, there were 7648 cases and 402 deaths from smallpox in this country during the first three and a half months of the present year, and 5267 cases and 272 deaths during the corresponding period of 1899. This is an increase this year of 44 per cent. in the number of smallpox cases and 48 per cent. in the number of deaths from that disease.

Beriberi Among the Japanese.—Kakké or beriberi has until recently been the most prevalent malady in the Japanese fleet, at times absolutely paralyzing action, just as formerly European squadrons used to be afflicted with scurvy. In 1882, during the Korean expedition, and about the same date, in a fleet off the coast of South America, beriberi rendered helpless between 30 and 40 per cent. of the total strength.

The Mosquito and Filaria Nooturna.—Dr Manson has succeeded in demonstrating the filaria in the blood, stomach, and other sections of the mosquito. In one microscopic section, passing through the entire length of the proboscis of a filariated mosquito, a specimen of this parasite was seen stretching along the entire length of the proboscis. It was inferred that the filaria is communicated to man by the bite of the mosquito. "This important discovery," says the *British Medical Journal*, "not only revolutionizes our ideas as to the precise way in which the mosquito conveys the filaria to man, but by analogy lends support to the truth of Ross' inoculation theory of malaria."

Some Medical Problems in the Philippines.—In an article in the *Atlanta Medical Journal* with the above title Dr. Bourns states that the Filipinos and the Spaniards at Manila know practically nothing about hygiene. But the Filipino is willing and quick to learn and will adopt whatever

is good and beneficial when convinced. Smallpox is always there. The native is a fatalist, and will not take any pains to avoid this disease, believing that if he is to die of it, it is so ordered. But while vaccination is resisted at first, when its utility is appreciated, the Filipinos will offer themselves voluntarily for vaccination. Leprosy is quite prevalent. There are about 2500 lepers in the islands.

Hygiene Exhibit for Paris.—An interesting exhibit for the Paris Exposition is that of public hygiene, which was shipped on May 5th. In the absence of a National department of health, Dr. Samuel W. Abbott, Secretary of the Massachusetts Board, special agent for the United States Commissioner, prepared the exhibit. All the States are represented, except a few in the West where there are only local health boards. The collection will be a part of the exhibit of social economy and public charities and hygiene. The following is a general enumeration of the articles comprised: Half-a-dozen large maps of the United States, illustrating subjects relating to the public health; a series of cards in wing frames, showing the vital statistics of the country as a whole, and of States and cities; maps and charts indicating the work of several State boards of health, of isolation hospitals for infectious diseases, of hospitals and homes for consumptives, of vaccine and antitoxin plants, and of crematories; six folios of circulars of State and local boards of health, and a large album full of photographs elucidating municipal healthwork; reports of the various health boards, of registers of marriages, births, and deaths, of dairy and food commissioners, and of sanitary organizations, and periodicals of the same class; a glass case containing appliances employed here to facilitate the diagnosis of infectious diseases, together with samples of antitoxines and vaccine lymph.

Yale Medical School.—The Yale Medical School is to be enlarged and to be removed from its present site in New Haven to Cedar Street, Congress Avenue and Rose Street in that city. The frontage of 400 feet is to be on Cedar Street, opposite the State Hospital. The land has cost from \$50,000 to \$75,000. The change will probably be made slowly, owing to the lack of funds. However, a new dispensary will in the near future stand on the proposed grounds. This change in the medical department is of a general scheme to develop, as far as possible, all branches of the University, illustrated some time ago by the university's purchase of the ground on which the new Law School building stands. The Yale Medical School is one of the oldest in the country.

Constipation.—

Rhei 3 ii
Magnesia 3 ii
Sacchari lactis 3 ii

M. Sig. Give as much as is held on the point of a knife twice a day in water.—v. *Widerhofer*.

OBITUARY.

LONDON CARTER GRAY, A.M., M.D.

DR. Landon Carter Gray, whose death was briefly noted in our last issue, afforded in the record of his life a notable example of how much, in results and in honors attained, can be accomplished within the brief compass of a few short years. Born in New York City April 3, 1850, he had barely passed his fiftieth birthday on May 8th, the date of his death. To those to whom the heritage of good birth is significant in its bearing upon the individual, it is interesting to note that Dr. Gray counted on both sides a long line of honorable and distinguished ancestors. His father, a lawyer of prominence and ability, was directly descended from "King" Carter of Shirley and Westover, two of the most famous Colonial estates of tidewater Virginia. His mother, a Miss Ireland, of the well-known New York family of that name, was a descendant of the Swedish Consul Jans, progenitor of the famous Anneke Jans heirs. Dr. Gray's boyhood days were passed at his father's home on Staten Island where he received his early education, afterward matriculating at Columbia College. He had scarcely completed his junior year, however, when he was compelled to abandon his studies on account of progressively failing vision, which had followed an attack of scarlet fever. This defect of vision was, by the way, of such pronounced character and degree as to render one eye practically useless through life, a statement which will doubtless surprise many who knew him intimately. The same illness appreciably affected his hearing, which defect also remained through life and was often a source of great personal annoyance to him. Upon leaving Columbia he went to Europe and, his eyesight improving, he entered the University of Heidelberg where he remained as a student for three years. Returning to New York he began the study of medicine, graduating from Bellevue Medical College in 1873. He was immediately offered, and accepted, the position of assistant to Dr. James R. Wood with whom he remained, however, only a year or two, finding no special aptitude nor inclination for surgery. He began practice in this city on Park avenue near 40th street. Within a year or two he moved to Brooklyn where he almost immediately began the special study of neurology. It was during these early years in Brooklyn that he passed through the fiery trial of financial adversity. Reared in an atmosphere of affluence and luxury he was the less prepared for the change which his father's total loss of fortune made necessary. In connection with this incident of his life it would be less than just to the memory of the man and to the dominant characteristic of his private life not to mention the fact that without legal obligation and with none other than that of the nicest honor, he voluntarily assumed and afterward paid, out of his own

personal earnings, thirty thousand dollars in settlement of the indebtedness incidental to his father's failure. The spur of necessity proved an additional stimulus to an already active ambition with the result that in less than ten years he had not only reached the top-most round in the city of his labors, but had won for himself a name and reputation reaching international proportions. At the age of thirty-two he was filling with distinction the Chair of Neurology in the Long Island Hospital College of Medicine. A few years later he resigned to accept the professorship of Mental and Nervous Diseases at the New York Polytechnic, a school for post-graduate instruction of which he was one of the founders. He returned to New York in 1886 where he continued actively at work until within two or three months of his death, persisting in a determination to continue "in harness" in spite of a constant distress of mind and body incidental to the disease which caused his death, which disease (a chronic nephritis with cardiac complications) was existent and known to him for several years.

His energy and worth were not unrewarded. Honors fell full upon him. His titles were many, only a few of which need be mentioned. He was Visiting Neurologist to St. Mary's Hospital in Brooklyn, Consulting Neurologist to the Hospital for the Ruptured and Crippled, President of the American Neurological Association, of the New York Neurological Society, of the Neurological Section of the Academy of Medicine, of the Society of Medical Jurisprudence and of the New York County Medical Society; Honorary Member of the Medical Society of the District of Columbia, besides many others. For nine years he held the position of chairman of the Executive Committee of the Congress of American Physicians and Surgeons, a most distinguished honor.

Dr. Gray was the author of many valuable contributions to neurology and psychiatry. He discovered and demonstrated the value of surface variations in the temperature of the scalp as a means of diagnosis in certain intracranial affections. He discovered and described a symptomatic entity among the convulsive disorders akin to chorea to which he gave the name palmus. Especially noteworthy and valuable were his original observations and published teachings upon syphilis of the nervous system, melancholia and the muscular atrophies. The crowning accomplishment, however, of his literary career is a treatise on mental and nervous diseases which has passed through several editions and ranks as a most valuable and authoritative text-book on the subject.

In no sphere of professional activity, however, did Dr. Gray attain to more deserved distinction than in that of the medico-legal expert. His opinions and advice were in constant demand, and he commanded a respect and confidence which cannot be better illustrated than by a tribute by one of New York's ablest jurists, a judge for many years of one of our highest courts, pub-

lished in the *New York Sun* of the 14th inst.: "Dr. Landon Carter Gray had also achieved notable distinction in the field of legal medicine. In giving expert evidence he was the very model of what a medical witness ought to be, and his intellectual honesty would not suffer him to be biased in favor of the litigant or lawyer who sought his opinion. This was so well known that distinguished counsel often consulted him in regard to medical matters which never found their way into court, simply in order to satisfy themselves as to the true character and extent of the injuries or maladies of which their clients complained."

Passing from the public to the personal man the task becomes more difficult. Dr. Gray was a many-sided man, and like all great men he had his angles. Of handsome physique, impressive presence and somewhat imperious manner, an acquaintance short of intimacy left often an impression less than just. To those who knew him no underestimate was possible. Of unswerving truthfulness, keen to exquisite nicety in his appreciation of the right, kindly and generous in every instinct, he was a type of the loyal friend and the generous foe. To him as to others of like type the cardinal crime was ingratitude and to repay an obligation with interest was with him instinctive. He was an intellectual pugilist and was never oblivious to the gauntlet thrown down before him. The atmosphere of the intellectual arena was as sweet incense and to this measuring of wits he went as to a feast. He never acknowledged defeat and yet he bore no malice from disaster accomplished by fair means. He was bold to audacity. To the writer he once said: "I always take the odd chance. In all my life I have never walked nor crawled, I have plunged." His sense of humor was always keen, his stories always apt. As an after-dinner speaker he was often in demand. As a teacher he was peculiarly coherent and practical. He possessed in extraordinary degree the quality of adaptability, which faculty made him preeminent as an instructor. He was a most voracious reader and, therefore, a "full man." His three years' residence abroad, coupled perhaps with natural aptitude, made him an accomplished linguist. One special quality he possessed in most phenomenal degree—a quality which has made the military chiefs of history—the faculty for organization. Of a child-like type of credulity apparently, he was accurate in his estimate of men and kept constantly attached to him by obligations of interest and gratitude men who not only served his purposes but justified his estimates in personal successes which cast a reflected glory, which was his. In this he suggested the elder Charcot. Of those who, in his special field, stand highest in New York to-day, not one but owes some tribute to his memory, the younger men for his determined efforts to check them in their fascinating but unfounded theories, and to the more mature for his loyal support in their well-considered theories.

CORRESPONDENCE.

OUR LONDON LETTER.

[From Our Special Correspondent.]

LONDON, May 10, 1900.

THE MIDWIVES' BILL—DINNER TO SIR WILLIAM MAC CORMAC AND MR. FREDERICK TREVES ON THEIR RETURN FROM SOUTH AFRICA—EFFICIENCY OF THE ARMY MEDICAL SERVICE—LARGE BRITISH LOSSES AND COMPARATIVELY SMALL BOER LOSSES IN ENGAGEMENTS—THE "PLAGUE OF WOMEN" IN SOUTH AFRICA—THE "HOME OF GENIUS"—DESCENT FROM ANCIENT CIVILIZED RACES IN THE PRODUCTION OF GENIUS—HEREDITY.

THE Midwives' Bill still remains the burning question of medical politics, so far as any question can be termed burning in a phlegmatic race and in a profession incapable of uniting and taking an active part in any public matter. This bill, which has passed its second reading in the House of Commons by a large majority, has been brought forward in order to regulate the practice of midwives. According to its provisions no woman will be allowed to use the title of midwife, or to hold herself out as practising as such, who has not been legally registered. In future to obtain registration a woman must undergo a prescribed course of training and pass an examination. She will be empowered to attend only normal labor; if complications arise a medical practitioner must be summoned. The majority of the rank and file of the profession appears to be hostile to the bill. They say it creates a new order of medical practitioner who necessarily will be imperfectly trained and that therefore their recognition will be fraught with disasters to puerperal woman. They insist that these midwives cannot in their limited course of training learn to diagnosis normal from abnormal labor. In a poll of the profession taken by the *Lancet* only 1311 out of 6299 practitioners expressed themselves in favor of the Bill. However, it must be remembered that of the whole profession in England and Wales not a third took the trouble to vote, so that the opinion of the silent majority is still in doubt. On the other hand, the opinion of the higher classes of the profession, so far as it has been expressed, is strongly in favor of such legislation. It has been recommended by the Obstetrical Society, the General Medical Council, and the Council of the British Medical Association. The leading medical journals maintain a very guarded attitude, which may be described as one of veiled hostility. The only one which has made an outspoken declaration in favor of the Bill is the *Practitioner*. It has the courage of its convictions and boldly declares that the opposition is conducted in a spirit of sordid selfishness and that in all the noise made by the leaders, but one argument can be detected, the *argumentum ad crumenam*. It must be confessed that this is largely true. The interests of the public have not even been considered by these gentlemen except

to furnish them with a fallacious argument. The question is not one of well-trained accoucheurs *versus* ill-trained midwives but of untrained *versus* trained midwives. From 50 to 75 per cent. of labors in this country are attended by midwives—in most cases because the fee of a medical man cannot be afforded. Puerperal fever is often spread by these ignorant and untrained midwives. With official training and supervision this could easily be prevented. As to alleged danger from the incapacity of midwives to recognize serious complications, the answer is: Trained midwives are much more competent to do so than untrained ones.

Sir William MacCormac and Mr. Frederick Treves have been entertained at a banquet by their fellow members of the Reform Club on their return from the South African War. Lord Roseberry presided and the Lord Chief Justice and many well-known politicians attended. The chairman proposed the health of the guests in a characteristic speech. He referred to the services of Sir William MacCormac in the Franco-German War which first brought him into prominence and to the sacrifice of these two distinguished surgeons who, without a second thought, at the call of the government, left their great practices to superintend the surgical arrangements of the army. In a war in which there was so much diversity of opinion, absolute and enthusiastic unanimity existed on one point and on one point only—that the medical service was perfect. In his reply Sir William MacCormac said that at the battle of Colenso in consequence of the adverse conditions under which the British forces fought, their losses amounted to 1140, while those of the Boers were 5 killed and 25 wounded. He knew this on good authority. The latter occupied an almost impregnable position which was shelled for two days. For every 1000 shells the Boer losses were only 12 killed and 40 wounded. Such was the result of modern improved guns! The injuries from rifle-bullets were mild and less destructive than he had ever seen before. Injuries from artillery were comparatively few. Mr. Treves said that there never had been a campaign in which the horrors of war were so mitigated by surgical aid. There were two plagues in South Africa—flies and women. The latter were an absolute terror. Having exhausted every form of excitement they came out in the guise of amateur nurses and were to be seen at Cape Town and other places gaily dressed and giving picnics. Considering the war in which the country was engaged this was a blot on the campaign.

In the current number of his *Archives of Surgery* Mr. Jonathan Hutchinson puts forward a very ingenious and fascinating hypothesis on the subject of genius. It is not, perhaps, generally known that in addition to his encyclopedic knowledge of the whole field of medicine, he possesses a minute acquaintance with biology in general and with the allied or subsidiary sciences of geology, anthropology, and history. The hypothesis to which I have referred is a characteristic prod-

uct of his subtle intellect; it is at once a daring and original hypothesis and a carefully made deduction. One of his patients has a head remarkably like that of Shakespeare. He at once asked him whether he was of Warwickshire family. The patient was, his ancestors having lived for many generations in Warwick, and he was of strongly pronounced literary tastes and abilities. Mr. Hutchinson had previously written a paper on the remarkable production of genius in the vicinity of Shakespeare's birthplace. Within a radius of fifteen miles of Coventry were born Shakespeare, George Fox, Butler, the author of "Hudibras," George Eliot, and Walter Savage Landor. Mr. Hutchinson suggests that possibly in this district there is some surviving Roman strain, for, here, in the very center of England the Romanized Britons were less disturbed than elsewhere. Here, too, was a confluence of Roman roads. Probably what is called genius is seldom or never produced in races only recently civilized, but occurs in those who in some degree trace their descent to the older stocks. The features of many European men of genius suggest an admixture of Semitic blood, and during the 360 years of the Roman occupation many of that race must have left descendants.

Prof. Arthur Thomson's lecture on "Heredity" at the Royal Institution of Great Britain, was an able and lucid exposition of an exceedingly difficult subject. Three kinds of inheritance were distinguished: (1) *Blended*, in which the characters of the two parents in regard to a particular structure, *e. g.*, the color of the hair, is intimately combined in the offspring. This form is well seen in hybrids and is probably the most frequent mode of inheritance. (2) *Exclusive*, in which the character of one parent is suppressed in regard to a structure, *e. g.*, eye-color. (3) *Particulate*, in which part of a given character is wholly paternal and part wholly maternal. Suppose the parents of a foal to be light and dark. If the foal is piebald the inheritance is particulate. Inheritance is not dual but multiple. A man, says Mr. Pearson, "is the product of all his past ancestry, and unless very careful selection has taken place the mean of that ancestry is probably not far from that of the general population. In the tenth generation he has theoretically 1024 tenth great-grandparents. It is the heavy weight of this mediocre ancestry which causes the son of an exceptional father to regress toward the general population mean." The transmissibility of acquired characters was considered not to have been established, but if the effects of "nurture" could not be entailed on the offspring, it was all the more important to secure for them good "nurture."

Death Penalty in Massachusetts.—By the narrow margin of two votes the House to-day decided against abolishing the death penalty in Massachusetts, the roll call recording 86 against and 84 in favor.

TRANSACTIONS OF FOREIGN SOCIETIES.

British.

CYSTS OF THE BREAST—DIAGNOSIS AND TREATMENT OF CHRONIC NASAL DISCHARGES—INCARCERATION OF A GRAVID UTERUS NECESSITATING ABDOMINAL SECTION AND CYSTOTOMY—CASE SIMULATING PERFORATED GASTRIC ULCER.

At a meeting of the Medical Society of London, April 23d, T. BRYANT spoke of cysts of the breast, to which he has given especial attention during the past four years. From personal observation he has been able to collect 242 consecutive cases of breast-disease. Excluding 12 of these in which the diagnosis was not confirmed by operation, there remain 163 cases of malignant trouble and 67 of cystic disease. Bryant draws the following conclusions: That simple cysts of the breast are far more common than they are generally thought to be; that they are chiefly found in women at the same period of life as that in which cancer is met with; that they are mostly amenable to local treatment without the sacrifice of the breast-gland in which they are situated; and that there is no reason to believe that women who have these cysts are more prone to cancer than those who have them not.

At the Harveian Society of London, April 5th, EDMUND ROUGHTON introduced a discussion on the diagnosis and treatment of chronic nasal discharges. He limited his remarks to the treatment of the accessory nasal sinuses. In antral empyema the essentials of treatment are: (a) The removal of the cause; (b) the evacuation and drainage of pus; (c) antiseptic irrigation; and (d) the removal of morbid material when present. Thus it would be futile to irrigate the antrum through the nose while it was constantly reinfected by carious teeth. Drainage alone will not suffice for a cure if the walls are polypoid, but it is wrong to scrape out an antrum which is simply a pus-receiver from a frontal sinus. In most cases treatment should be begun by antral drainage with a fair-sized tube. When this does not succeed the radical operation can be resorted to, an opening being made through the canine fossa. The treatment of frontal empyema is divided into intranasal and extranasal. The former comprises removal of the anterior part of the middle turbinate and irrigation of the cavity through the infundibulum. If these methods fail extranasal treatment may be resorted to, for instance, if there is persistent pain or evidence of imperfect drainage. Ethmoidal suppuration should be treated by the removal of the middle turbinate and scraping of the affected cells, care being taken not to transgress the anatomical limits of the lateral mass of the ethmoid. Any direct operative attack on the sphenoid should be undertaken only after the most careful consideration.

HERBERT TILLEY said that the pain of chronic suppuration is due to accumulation of pus under

pressure and not to inflammation of the nerves in the walls of the sinuses. In support of this opinion cases were cited in which the pain had instantly disappeared as soon as free drainage had been secured by the removal of a tooth, irrigation of the antrum from the nose, or the removal of the anterior half of the mid-turbinal, and of obstructing polypi and granulations from the region of the mid-meatus. In testing for pus in the antrum by transillumination, the patient's comparison of the subjective sensation of light in the eyes is sometimes of more value than the surgeon's comparison of the facial illumination. Tilley believes in antral drainage as a preliminary measure in all cases of antral suppuration. It is a simple method of treatment and often cures the patient. It can usually be carried out without the removal of a sound tooth.

At the Obstetrical Society of London, April 4th, J. M. KERR reported three cases of incarceration of a gravid uterus. In one of them the operator found it necessary to open the abdomen and then the bladder, and was unable to replace the uterus until he had removed a large quantity of blood-clot from the bladder. The bladder and abdomen were then closed. The patient recovered and continued to full term.

A. H. N. LEWERS criticised this method of treatment, saying that he had seen many cases in which the retention of urine was extreme, over five pints having been drawn off, and in two of the cases there was hematuria, but the performance of abdominal section was not suggested. His treatment was to empty the bladder and to replace the uterus, preferably under anesthesia, or to encourage the uterus to rise spontaneously by rest in bed and regular evacuation of the bladder. Such spontaneous reposition is not unusual. In the case mentioned by Kerr the urethra might have been dilated and the clots removed by forceps and irrigation, and if the bladder had only been kept empty for a few days with the patient constantly in bed, he suggested that the uterus would have spontaneously assumed a correct position.

At the Royal Academy of Medicine in Ireland, March 9th, W. J. THOMPSON read notes on a case simulating a perforated gastric ulcer. The patient was a female, aged twenty-three years, who had a tubercular family history but who had never been seriously ill except for a period of six weeks. She suffered from mild digestive disturbances, flatulence and nausea. Later there was pain, localized at first in the pit of the stomach and afterward extending to the back. About an hour after a simple supper of bread and milk, the pain suddenly became agonizing and was followed by vomiting; the vomited material being, according to report, of dark reddish color. The pain increased during the night and became more diffuse. The epigastric and left hypochondriac regions were tense and tender. Liver dulness was present. Fourteen hours after the acute attack the abnormal symptoms were aggravated,

the pulse 140, respiration 34, temperature 102° F. A median incision was made and the anterior wall of the stomach examined. It appeared normal. The operator was about to examine its posterior wall when he discovered a coil of jejunum containing two gangrenous patches involving one-third of the bowel. The loop was resected and the ends joined by a Murphy button. The patient recovered. The specimen was lost and the cause of the gangrene was not determined, but the case is of interest as showing how difficult is an infallible diagnosis of acute abdominal lesions. The previous history, the sudden nature of the attack, and the localization of pain all pointed to perforation of a gastric ulcer.

SOCIETY PROCEEDINGS

AMERICAN SURGICAL ASSOCIATION.

Twenty-first Annual Meeting Held at Washington, D. C., May 1, 2, and 3, 1900.

THIRD DAY—MAY 3D.

(Continued from Page 714.)

Surgery of the Stomach.—The discussion was opened by Dr. W. W. Keen of Philadelphia, who said that the subject naturally divided itself in benign troubles and malignant troubles, and of these two classes the latter is the more difficult and more important. It is practically in the first three months that the surgeon must operate on carcinoma of the stomach if he expects to be successful. The advent of gastric specialists is a great help to the surgeon, but in every case in which there is a suspicion of cancer, if medical measures fail to relieve, an exploratory operation should be made without delay.

Dr. M. H. Richardson of Boston said that in stomach diseases, all methods of diagnosis should be exhausted before exploratory incision is performed. Explorations of the abdomen are dangerous. When other means of diagnosis have been exhausted and a doubt remains, then an exploration should be made, and, just as in acute cases after traumatism and so forth, the exploration should be made without delay. The future of surgery of malignant disease of the stomach is more hopeful than is generally believed.

Dr. Thomas A. McGraw of Detroit called the attention of the members to a method of gastro-enterostomy by elastic ligature which was first performed by him upon a human being in 1891. The junction of the stomach and intestine was perfect. The patient died in fifteen days of inanition, and at autopsy the surgeon found that he had anastomosed the very lowest part of the ileum to the stomach. One advantage of this operation is that it is the safest form of gastro-enterostomy. The rubber ligature can be stretched and threaded through a darning-needle smaller than the ligature. Hence the opening made in the stomach

and intestine will be smaller than the rubber thread which passes through them and no leakage can occur. The speaker said that he has performed this operation many times upon dogs with entire success. In the dog it takes four days for the portion of the stomach which is included in the ligature to slough away. In man the length of time required is probably three days.

Dr. Allen of Detroit mentioned a case of perforated ulcer of the stomach which was situated so far posteriorly that it was impossible to reach it. The patient was quickly put into Trendelenburg's posture, and the fluid and gas were removed from the stomach by a stomach-tube. The area of the perforation was stuffed with gauze, and the patient recovered. Culture media inoculated with the peritoneal fluid remained sterile.

Dr. Tiffany of Baltimore said that he had seen but one case of carcinoma of the stomach, and that at autopsy, in which the condition was such that an operation could be done with reasonable expectation of a radical cure. The speaker advocated an exploratory operation in order to make a diagnosis. He said that surgeons came to their present knowledge of ovarian troubles only by operating many times and often needlessly, as they have since learned; that the same is true of appendical difficulties; and that knowledge of gastric lesions and the best means to meet them must be acquired by the performance of many operations, wise and otherwise.

Dr. R. F. Weir of New York said that the surgeon is called upon to relieve one or more of the major symptoms of pain, hemorrhage, delay of food in the stomach or dilatation. When the abdomen is opened he must then decide as to what operation will best relieve the symptoms. Speaking of the technic of gastro-enterostomy he said he preferred the posterior method combined with entero-anastomosis of the ascending and descending legs of the intestinal loop. Since adopting this procedure he has never seen the vicious vomiting which formerly caused the death of some of his patients after gastro-enterostomy. He prefers a Murphy button not only because of the facility with which it can be employed, but also because its punched-out hole gives security against subsequent contraction which is not offered by even a long sutured slit.

Dr. Armstrong of Montreal said that he had operated on a number of cases of hemorrhage of the stomach. These cases are of two classes, one in which superficial vessels are opened and which are amenable to medical measures, and those in which a deep and large vessel is opened, and in which death quickly follows either the first large hemorrhage or a succeeding one. The stomach should be opened in the anterior wall so that its inner surface may be most satisfactorily explored. Then, if necessary, a pyloroplasty or other suitable operation may be done.

The Methods of Closing Abdominal Incision.—Dr. M. H. Richardson said that for various reasons he favored a through-and-through suture. It leaves no dead spaces to be filled with fluid, and

so give rise to sepsis. Hence, herniotomy sutures being in layers are especially liable to supuration. Silkworm gut is preferable to silver wire since it has all the advantages of wire and can be more rapidly put into place. The buried silk suture is best for the ligation of arteries as well as for layer sutures. Hematomata of different parts of the body show a different predisposition to infection. Those of the breast and amputation stumps do not usually become infected, while in a hernia the blood-clot almost always does so. This difference is probably due not to the suture material, but to the dirty operative field. Every operative field has some micro-cocci in spite of all attempts to cleanse it, and this is particularly true of the region of a hernia. There are very few ventral hernias after aseptic operations. The through-and-through suture obliterates the dead spaces, especially between the peritoneum and the muscular layer. If a buried suture is wished the muscular layer should be sutured. Then with a through-and-through suture the whole wall is firmly closed.

Dr. Deaver of Philadelphia endorsed Dr. Richardson's views. He is sceptical in regard to the sterilization of catgut. Whenever it is possible to do so, incision should be made through a muscular portion of the abdominal wall.

Dr. R. F. Weir of New York said that the disadvantages spoken of as due to the layer suture might have other explanations; for example, tying a suture too tightly may cause death of tissue and so give rise to hernia. The men who perform abdominal operations very likely do not see patients who afterward, disappointed with the result of their operation, apply to another surgeon for relief of a ventral hernia.

Dr. G. R. Fowler of Brooklyn advocated a figure-of-eight suture so that the threads cross between the peritoneum and the muscular or fascial layer. He considers that a purse-string suture of the peritoneum is less likely to be followed by adhesions and hernia than is a linear continuous suture.

Dr. Coley of New York said that clinical evidence has demonstrated the aseptic qualities of properly-prepared catgut. He referred to the last 150 cases of hernia in which operation has been performed at the Hospital for Ruptured and Crippled in New York City only absorbable sutures being employed. In but a single instance was there suppurative of the wound, and cultures of the skin of this patient made at the time of operation, and cultures afterward made from the discharge of the wound both contained the same streptococcus while tests of the catgut showed it to be sterile.

Dr. Nancrede of Ann Arbor said that catgut can be made as sterile as anything else by boiling it in kumol at 160° to 170° C., as has been shown by repeated laboratory tests; while it has also been shown that the ends of a sterile catgut ligature contain the same germs as the bare hand of the man who ties the ligature.

Dr. Ransohoff of Cincinnati said that the con-

tinuous buried suture can be used rapidly and easily in layers. His plan is to put a buried suture in the peritoneum, and in the muscular layer a continuous suture, the ends of the latter being brought out and through the skin. He then closes the skin by an intracuticular suture. It is better for a patient to have a single linear scar than one with numerous crossbars.

Strangulated Hernia Through Rupture of the Diaphragm.—Dr. E. W. Walker of Cincinnati reported an instance of this rare condition, the result of an accident, which was successfully relieved by operation. The incision in the median line revealed, after some search, a knuckle of prolapsed bowel tightly pressed into a rent in the diaphragm. It was withdrawn and an attempt was made to suture the rent in the diaphragm, but owing to the labored respiration of the patient the attempt was abandoned and the abdomen was closed. Recovery was uneventful.

Hernia of the Bladder Through the Pelvic Floor.—Dr. Francis B. Harrington of Boston reported a case of fibroma with attachments extending from the left labium magus to the left buttock. The tumor arose from the subperitoneal tissues in front and to the left of the bladder. It had drawn the bladder out of the pelvic cavity through the fibers of the levator ani muscle. Nearly the entire bladder was enveloped by the tumor which hung between the patient's legs. The tumor was 18½ inches in circumference and 8½ inches long. When the bladder was emptied the tumor decreased 2½ inches in its circumference. The bladder held 22 ounces of urine without discomfort. The urine did not flow until a soft rubber catheter had been inserted 8 inches. The tumor was removed and the hernia of the bladder reduced by a combined abdominal and external operation. The broad ligaments were separated from the uterus and the fundus of the uterus was drawn forward and to the left and sutured in that position as a plug to prevent the recurrence of the hernia. The operation was entirely successful and when seen six months later there had been no recurrence of the hernia of the bladder. Hernia of the bladder through the pelvic outlet is a very rare condition. No case, according to Brunner having been recorded in medical literature since 1860.

Aneurism of the Renal Artery.—Dr. W. W. Keen of Philadelphia operated with success upon a tumor supposed by him to be a sarcoma of the right kidney. The tumor was so vascular that its pedicle had to be ligated in seven places to control the hemorrhage, but it was not until the tumor had been removed and cut into that it was seen to be an aneurism. Aneurism of the renal artery is one of the rarest forms of aneurism, only twelve other cases having been reported. The cause in six cases, including that reported by Dr. Keen, seems to have been an injury. In most cases no disease of the general arterial system seems to have been present. Pain is not a prominent symptom. The tumor is usually smooth and elastic and, if it follows an injury,

it grows less rapidly than does a hematoma, but more rapidly than a sarcoma. The sac is very large and the artery relatively small and, hence, pulsation has not been noted in more than one instance. Without pulsation, naturally, a thrill would not be present, although in only one instance is it mentioned that the surgeon auscultated the tumor. One of the most important symptoms is hematuria. If the aneurism is situated outside of the kidney this will not take place until the aneurism attains considerable size and bursts into the pelvis of the kidney. In one case it developed within the kidney and there was hemorrhage from the first. Only three patients have been operated upon, and they all recovered. There was nothing peculiar about any of the operations, other than the danger of hemorrhage from the pedicle.

Acute Tuberculosis of the Mesenteric Glands.—Dr. M. H. Richardson of Boston said that he had come to look upon this disease as hopeless, unless the glands could be removed by operation just as is done in tuberculosis of the neck. The miliary form of peritoneal tuberculosis is not accompanied by enlargement of the mesenteric glands. When they are distinctly enlarged, ascites is generally absent. The mesenteric glands may be found enlarged, in cases of chronic appendicitis or under other conditions. They may be caseated or even calcified. In acute appendicitis the nearest glands may be distinctly affected. It is by no means unlikely that the original trouble is an acute tuberculous affection of the appendix, which may not be recognized as such until a persistent sinus or the progress of the disease in the glands reveals the true nature of the lesion. In the case reported diagnosis of acute appendicitis was made, but the appendix was found to be normal. Several enlarged and inflamed glands were removed from the mesentery, most of them were juicy, two contained cheesy degenerated areas. The operation was performed five years ago and the boy is still in excellent health.

Congenital Cystic Tumor of the Pelvis.—Dr. De Forest Willard of Philadelphia reported the occurrence of the above-mentioned trouble in a neurotic man. On account of the pain which extended down his leg, his physicians had made a diagnosis of neuritis; but the pain did not follow the course of any nerve, and was not continuous. Afterward a tumor was found in the groin and was operated on. It was of a cystic character and was so intimately connected with the iliac and femoral arteries that it was impossible to remove it *in toto*. Numerous bean-shaped yellowish bodies were taken from the cyst the nature of which was not clearly ascertained. The patient died later of nephritis.

Carcinoma.—Dr. L. Freeman of Denver mentioned two unusual phenomena in connection with carcinoma. A woman aged thirty-five years, from whom a carcinomatous breast had been removed, suffered spontaneous fracture of the femur while turning in bed. Apparatus was applied and, contrary to all expectation, the bone

firmly united. After the death of the patient sections of the femur showed that the cancer had invaded the bone through its Haversian canals. In another patient an apparently typical cancer of the lip disappeared spontaneously. Later the submaxillary glands became enlarged and were removed. Microscopic examination showed them to be carcinomatous.

AMERICAN GYNECOLOGICAL SOCIETY.

Twenty-fifth Annual Meeting, Held at Washington, D. C., May 1, 2 and 3, 1900.

(Continued from Page 728.)

FIRST DAY—MAY 1ST (Cont.).

Conservative Surgery.—Dr. W. L. Burrage of Boston read a paper, entitled "The Remote Results of Conservative Operations on the Ovaries and Tubes, with Analyses of Eighty-five Cases." After referring to the results obtained by Drs. Polk and Dudley in this line of work, he gave a most thorough analysis of his cases and reached the following conclusions: (1) It is advisable to do conservative operations in all cases where the tubes are not hopelessly diseased in all parts of their stricture, except on patients who are near the menopause, on patients who have pronounced gonorrhea of long standing, and on the rare cases of malignant disease. (2) When a patient is near the menopause (over 35 years of age) and has ovarian or tubal disease of any considerable degree of severity it is generally wiser to perform complete removal with or without hysterectomy according as the uterus is diseased or not. (3) In cases of well-marked gonorrhea of long standing, especially if the patient is constantly exposed to reinfection, if both tubes are seriously diseased and closed total removal, with or without hysterectomy, is the operation of choice. (4) In certain cases of this class where the patient thoroughly understands the likelihood that another operation may be necessary at some future date and wishes to take the chances in the hope of preserving the functions of menstruation, conservative operation is permissible. (5) If one tube is patent and healthy in appearance and there is enough healthy ovarian tissue to preserve, a conservative operation ought to be performed even in the presence of gonorrhea. (6) With present methods of performing resection of the tubes, if both tubes are found closed at the time of operation subsequent pregnancy is not to be expected. (7) In severe grades of inflammation of the appendages irrespective of causation if the ostium abdominate of one tube is patent the prospect of subsequent pregnancy after the preservation of a portion of the ovary is about one in four and a quarter or 23½ per cent. (8) In the lesser grades of inflammation under similar conditions of tube and ovary the prospect of subsequent pregnancy is about one in two and a quarter or 44 per cent. (9) In women who have borne children, in both classes, subsequent preg-

nancy may be expected in 35 per cent., whereas in the previously sterile it may be looked for in only 5 per cent. (10) If it is necessary to remove both ovaries, it is of no advantage to preserve any portion of tubal tissue, but, except under the conditions just enumerated, some ovarian tissue should be preserved in every case.

Dr. Thomas Addis Emmet of New York opened the discussion by saying that one should always be conservative for nature can do wonders at repair. It is of benefit to leave even the smallest possible bit of healthy ovarian tissue. This was well exemplified by two cases in which he had pursued this course, and subsequently both patients became pregnant.

Dr. Dudley of New York said that he had now performed the conservative operation in 138 cases without a death. In one of these cases, which was a gonorrheal infection, there was a double pyosalpinx. He removed one ovary and split the other one and removed a V-shaped piece. He separated this from the tube and buried it in the fundus of the uterus. The ovary grafted and since then the patient menstruated normally. He had had 5 cases in which he has transplanted the ovary with marked success. Two of them are now menstruating; 1 has not yet had time to menstruate; 1 was never seen again, and 1 is not menstruating. The function of menstruation should always be conserved if possible and the patient thus spared the nervous shock.

Dr. Harris of Paterson, N. J., says that it is very rare to have to remove all or both ovaries. The only cases in which he does so are those which have large abscesses in the ovary. There are many advantages in leaving the ovaries from the standpoint of health as well as that of sentiment. It is believed that the future will show many cases of pregnancy as the result of such conservative treatment.

Dr. Vineberg of New York said that the class of cases which give the poorest results are those in which the lesion is not very severe; no matter what treatment is employed, the patients continue to suffer after operation.

Dr. Mann of Buffalo reported a case in which he had removed one tube and one ovary, the other tube and ovary being also infected. He did not remove them but merely incised them. Since then the woman has given birth to three girls and one boy, and is a splendid example of the good results to be obtained by conservatism.

Dr. Goffe of New York said he always believed in conservatism and was now approaching his one hundredth operation in which he had practised it. He prefers the vaginal route to the abdominal, and uses the actual cautery to burn out cysts in the ovary. In one case he removed two-thirds of the right ovary and applied the cautery six times to the left ovary. The woman is now pregnant.

Dr. Hunter Robb of Cleveland reported a case which had not been very successful. He performed a conservative operation at first, but in six months the patient had many distressing symp-

toms, so he made an abdominal incision and found that both ovaries were densely adherent and that the surface of the ovary had become converted into a blood-cyst. He removed both ovaries.

Dr. Burrage closed the discussion by saying that he had used the cautery on many cystic ovaries, but that he did not believe it had any advantage over simple puncture. He thought that every case should have a careful bacteriological examination made before operation, as the knowledge thus gained would be a guide as to the method of procedure, or, in other words, as to whether a radical operation was imperatively demanded, as would be the case in tubercle infection.

Internal Secretion of the Ovary.—This was the title of the paper read by Dr. Arthur W. Johnstone of Cincinnati. He said that there is absolutely no proof that the ovary has any other function than the manufacture of eggs. During all the life of the individual the Graafian follicles ripen. The ovary is in no sense a gland. Its epithelium is arranged for the purpose of being cast off and lost, and it is not placed so that its secretions, if it have any, could be absorbed either by ducts or blood-vessels. Delayed menstruation in a child-bearing woman produces identically the same symptoms as those of the menopause, which would certainly make the internal secretion of the ovary seem a myth. He does not believe the ovary dominates the health of woman, but rather that there is a center in the spinal cord which is the controlling factor. The good results following the administration of ovarian extract are generally seen in hysterical women who have also been known to improve on a mixture of salt and soda. Nature has its periods of rest and work, as seen in the moulting of birds, which corresponds to the menstruation of woman. It is simply a time of increased oxidation. Some women stand this period well, while others, particularly those with the gouty diathesis, do not. This is a very large source of trouble at the menopause and during menstrual life. In proof that the ovary's influence is not paramount, the author cited a case of a girl who had both ovaries removed on account of cysts at the age of 8 years. When seen twelve years later she had developed into a beautiful woman, her figure well rounded out, the possessor of a good voice, and an examination of her external genitals showed them to be perfectly normal.

Suturing the Round Ligaments.—Dr. H. N. Vineberg of New York read a paper on "The Technic, Indications and Ultimate Results of Suturing the Round Ligaments for Retroversion and Retroflexion of the Uterus." He describes his technic as follows: The patient is prepared as she would be for a vaginal hysterectomy. The nymphæ are sutured to the skin of the thighs so as to keep them out of the way. The cervix is then seized with two vulsella and forcibly drawn outside the vaginal orifice and downward, and

the anterior vaginal wall is caught with another vulsellum near the urethral meatus and drawn upward, thus putting the anterior vaginal wall on the stretch. With a sharp scalpel or one with a convex blade a longitudinal incision is made, extending from the urethral mound to the vaginal attachment of the cervix. The two flaps thus created are now separated partly by blunt and partly by sharp dissection from the underlying bladder. In order to give ample room generous separation of the vaginal flaps should be made. The lower angles of the flaps are then held apart and the cervicovesical septum is divided by a semilunar incision about 1 cm. below the lowest attachment of the bladder to the cervix. Before making this incision it is prudent to pass a sound into the bladder and ascertain how far down upon the cervix the bladder reaches by gently pushing the sound downward and forward. The bladder is next pushed up from the uterus with the index finger, as is done in vaginal hysterectomy. A short vaginal retractor is now inserted into the anterior opening, thus keeping the bladder out of the way and exposing the vesico-uterine fold of peritoneum. The fold is caught with forceps and a transverse incision made with scissors just below their bite. Before loosening the hold of the forceps a suture is carried through the peritoneum above the point of the incision, and it is left long and clamped. Its purpose is to draw down the bladder peritoneum towards the end of the operation when the slit made in the peritoneum is sutured. The cervix is now pushed backward into the posterior fornix with the vulsella, thus tilting the body of the uterus somewhat forward, and with the anterior vaginal retractor in place a traction suture is carried by means of a short, stout needle through the exposed anterior uterine wall as high up as possible. With this suture the uterus is further anteverted and brought into the incision. It may take one or more additional traction sutures, each carried higher up on the uterine wall, to completely deliver the fundus through the incision. With the index and middle fingers the adnexa, one after the other, are brought into the incision, subjected to visual inspection, and to such surgical treatment as their condition calls for. It is astonishing with what ease in the majority of cases a resection of an ovary or of a tube can be accomplished in this manner. The adnexa having been replaced within the peritoneal cavity, the uterus is retracted to one side, and with a small fine needle a silkwormgut suture is carried behind the round ligament of the opposite side about three or four cm. from its insertion into the uterus. Some care is necessary in passing this suture to avoid the small arterial branches which supply the ligament, as a troublesome hemorrhage may occur from the needle piercing one of them. A second suture is passed in the same way one or two cm. nearer the uterine insertion. The ends of the sutures are secured above and below with small

artery clamps, which may be numbered so as to avoid confusion when it is necessary to carry the sutures through the vaginal flaps. This procedure is repeated on the opposite side and the uterus is returned within the peritoneal cavity by pushing the fundus backward with the fingers and drawing the cervix downward and forward with vulsella. The outer round ligament suture is now carried with a leading suture through the vaginal flap at a point corresponding to the anterior lateral sulcus and as near the pubic arch as possible. The inner suture is passed through the flap at a suitable distance inward from the first. The same thing is done on the opposite side and the sutures are tied loosely in the vagina while the uterus is being held forward by means of the traction sutures. The traction sutures are then cut and removed. The upper edge of the peritoneum is next drawn down by means of the suture which is attached to it, and the slit in the peritoneum is closed by a continuous catgut suture. In the event of a cystocele or a redundant anterior vaginal wall having been present, a strip of suitable width is excised from each vaginal flap, and the two flaps are coaptated by a continuous catgut suture. The last couple of stitches are made to catch up the cervical tissue so as to attach the vaginal wall to the cervix, as normally obtains. When the uterus is unusually large and heavy, or when the uterorectal ligaments are put on high tension by anteverting the uterus, it is wise according to my experience to employ a single uterine fixation suture in addition to the round ligament sutures. This suture should not be placed too high upon the uterine wall so as to avoid the possibility of dystocia in the event of pregnancy. Finally, any operation on the cervix that may be called for is now done, and the posterior vaginal wall or peritoneum subjected to any plastic operation that may be deemed necessary. The patient is kept in bed for twelve days, at the end of which time the round ligament sutures may be removed, as may also the uterine suture if present.

Dr. Cushing of Boston opened the discussion by saying that he does not think there is anything new in the first part of this operation. He considers it better to do it from above and should only do it in those cases where it desired to operate on the cervix at the same time. He prefers to operate through an abdominal incision as then he is able to see all the organs and can remedy all defects that are apparent.

Dr. Sutton of Pittsburg said that he had done this operation with uniformly good results. It is to be hoped that the time is not far distant when the majority of abdominal operations will be performed through the vagina. At present it is possible to remove large fibroids or ovarian cysts by this route.

Dr. Bovée of Washington said that he sees little use for shortening the round ligaments through the vagina as Alexander's operation is a better one, there being no opening of the peri-

toneal cavity. The greater number of cases of uterine dislocation are due to injuries to the pelvic floor either as the result of childbirth or else through the faulty attachment of the fascia. The great point to be observed is to properly adjust the ligaments. If they are attached too high, lower them, or, if they be relaxed, take a reef in them. In other words, correct the deformity present in each particular case. When the fascia is torn high up the abdomen should be opened, the peritoneum dissected up, and the torn fragments brought together and sutured. Generally pelvic adhesions are present in all forms of dislocation of the uterus, so when performing Alexander's operation it is well to open the inguinal rings and explore the pelvic cavity before completing the operation. Constipation and infrequent urination are often the cause of failure after Alexander's operation.

SECOND DAY—MAY 2D.

Vaginal Route.—Dr. J. Riddle Goffe of New York continued the discussion of Dr. Vineberg's paper and said that the era of doing all pelvic operations by the vaginal route has arrived. No laparotomy is justifiable until an attempt has been made to perform the operation through a vaginal incision. The work can be performed quite as successfully as it can through the abdomen. He has performed myomectomy, and operated on ectopic gestation, dermoid cysts, salpingitis, etc., with great success by the vaginal route. In his opinion the best operation for the cure of retroversion is by making the incision through the vagina, then double the round ligaments on themselves. It is a much better operation than Alexander's, as it is applicable to all forms of displacement whatever their complication. In one patient he removed seven fibroid tumors by myomectomy through the vagina and at the same sitting cured a long standing retroversion by shortening the round ligament.

Dr. Sutton of Pittsburg said that he preferred the vaginal route to the abdominal, as drainage was always very much better through the vaginal vault than through the abdominal walls. Dr. Vineberg closed the discussion by saying that he had taken up the vaginal route because ventrosuspension by the abdominal method had not given good results in his hands. Each case should be considered very carefully for a certain proportion will require operation by the abdominal route.

A Comparison of Vaginal and Abdominal Operations, by Dr. G. Richelot of Paris, France, was then read by title and will appear in full in a subsequent issue of the MEDICAL NEWS.

Demonstrations of Casts Illustrating the Anatomy of Pregnancy and Labor.—These were shown by Dr. J. Clarence Webster of Chicago. The casts were made of plaster of Paris and had been modeled after frozen sections. They were an interesting demonstration of the good results which may be accomplished in this line of work.

Combined Nephrectomy and Ureterectomy.—Dr. E. E. Montgomery of Philadelphia said that he wished to report one case. It was that of a woman aged twenty-seven years whose family history was negative as was also her previous history, except that she had had several attacks of what she called inflammation of the bladder. These attacks were characterized by frequent and painful urination and a dull aching pain in the region of the right kidney which at times was relieved by the discharge of large quantities of urine. She has had some night sweats but she has no cough or expectoration. Her appetite is capricious and her weight 118 pounds, a loss of 32 pounds in the past five years. An examination of the urine showed pus and epithelial cells but no blood corpuscles, casts, albumin or sugar. Bacteriologic examination failed to show the tubercle bacillus. On examining the bladder with the cystoscope it was found that the walls were thickened and roughened and that they bled easily. After irrigating the bladder a Harris apparatus for separating and collecting the urine from each side was introduced. Urine was not obtained from the right while the urine flowed freely from the left. Examination of this urine showed it to contain pus and epithelium, but no albumin, casts, blood corpuscles or sugar. Examination for tubercle bacilli was negative, but the streptococcus was present. On making a careful physical examination, a semifluctuating mass was found on the right side at the level of the umbilicus, extending nearly to the median line. A pelvic examination showed the uterus to be slightly enlarged and somewhat movable. On the right side there was a marked indentation between which and the uterus the finger could not be passed. Despite the absence of bacilli in the urine the diagnosis of tuberculosis of the ureter and kidney was made and immediate operation was decided on. An incision was made in the vagina over the line of the right ureter and the tissue pushed back until the ureter was exposed as a hard dense cord as large as the finger. The ureter was then ligated and then divided with scissors, but unfortunately, in accomplishing the division the ligature and the uterine artery were cut. The latter was secured by pressure forceps. The introduction of a catheter through the urethra also demonstrated that the bladder had been opened. The vagina was packed with gauze and the patient turned on her left side and an incision was made in the right lumbar region. This exposed the kidney which was very nodular and contained about a pint of pus. This was evacuated and the kidney then removed. The ureter was then dissected out and the operation was completed by packing above and below with iodoform gauze and suturing all but the upper angle of the lumbar incision, which was left open for drainage. The woman made an uninterrupted recovery. Examinations of the specimens removed showed them to be tuberculous.

Anastomosis of the Ureters with Intestines.—

A full abstract of this will appear later in the MEDICAL NEWS. The discussion was opened by Dr. Ford, who said that he would speak of an interesting case that had lately come under his observation. It was that of a young woman who came to him with the statement that she could only pass about one ounce of urine a day. Examination showed that practically no urine was entering the bladder, but instead it was all being passed through the bowels. The uretero-intestinal anastomosis occurred spontaneously from the passage of a calculus. Palpation failed to reveal the presence of the right kidney, while the left is clearly demonstrable, so he believes that she had only one. For the past year she has been passing about all her urine through the bowel and is apparently in perfect health. Repeated examinations of the urine have failed to reveal any evidences of infection of the kidney.

A Critical Survey of Ureteral Implantation.—

Dr. W. Bovée of Washington read this paper and said that injuries of these ducts are apparently becoming much more common. These injuries take many forms, varying from the kinked ureter to the unintentional removal of several inches of the organ. Previous to 1877 there had been but two ways of dealing with a complete section of the ureter. These were the let-alone policy and nephrectomy. It is very probable that but for the popularity of nephrectomy, ureteral surgery would have had a much earlier elaboration. An only kidney was removed but a few years ago in this country, as was disclosed by the autopsy, and anuria existed twenty-nine days before death ensued. Practically all surgeons are now agreed that for severed ureter without much loss of tissue the best procedure is to unite the severed ends. This had been done by four different methods: (a) The transverse end-to-end method has been performed twelve times with two deaths, (b) the oblique end-to-end, once and the patient recovered; (c) the end-to-end, nine times with one death; (d) the lateral implantation or end-in-side, five times with one death. This gives a total of twenty-seven cases in which the cut ureter was directly united and of these four died. After all operations for the repair of the ureter the point of danger is the narrowing of the lumen of the duct by granulation. Uniting the ureteral ends is by far the best method of disposing of the divided ureter whenever this is possible, but it is difficult to decide which method is best suited for all cases. The peculiarities of each individual case and the preferences of the operator must decide each case on its merits and no general rule can be laid down. Considering the other operations for the relief of a divided ureter we find that ureterocystostomy has been performed eighty times. This is a much easier operation than ureteral splicing, which accounts for the number of cases in which it has been done. Of the thirty-seven bladder grafts for injuries of the ureters during abdominal operations, we find that fifteen were done by the intra-peritoneal method at the time of the injury with the result that one case died of

extraneous causes and in two cases there was failure. Two were done by the extra-peritoneal plan and the statistics of the remaining number of cases do not state which plan was followed, but one case resulted in a failure. Of the cases done for fistula or other conditions it is found that there were forty-two, of which twelve were intra-peritoneal operations, fourteen by extra-peritoneal operation and in sixteen the method was not mentioned. This operation is especially indicated when in the course of an abdominal operation, section of the ureter in its pelvic portion is made and it is impossible or inadvisable to splice the cut ends. Ureteral fistulae following operations, difficult labor or forceps delivery and congenital ureteral openings are also indications. Ferguson collected the statistics of 67 cases of ureteral fistula and found that 25 of them were created in parturition, in 16 of which the delivery was by forceps. In 12 cases vaginal hysterectomy was the cause, 2 were due to stone in the ureter and subsequent ulceration, 3 followed abdominal section, 1 was due to traumatism, 2 resulted from pelvic abscesses, 1 was spontaneous (probably tuberculous), 1 from a pessary and 1 from an undilatable stricture of the lower end of the ureter. In utero-vaginal fistula it is only occasionally that cure can be accomplished by vaginal plastic surgery and there is always the danger of relapse from a heavy strain or from cicatricial contraction. The methods of bladder grafting are principally by the abdominal route preferably by the extra-peritoneal method. It is impossible to make an anastomosis between the ureter and the bladder as good as the natural one, because the small muscles attached to the ends of the ureters and lost in the walls of the bladder near the internal meatus can not be utilized. Their function is to draw down the orifice of the ureter when the bladder distends, thus preventing obliquity of that duct through the distended bladder. The observation of careful surgical technic in all operations on the ureter is of the very highest importance, as a very slight infection may render the operation unsuccessful and endanger ascending infection along the ureter. Whenever the ureter requiring grafting is above the brim of the pelvis and ureteral anastomosis with itself or the bladder seems impossible one should consider the advisability of its implantation into its fellow. If this be impossible, then grafting into the bowel will be justifiable. Rectal implantation is indicated in the treatment of ectopia vesicæ, benign and malignant growths of the bladder, requiring the extirpation of that organ, and injuries of the ureter irremediable by ureteral or bladder anastomosis. Many hundreds of experiments have been made on animals to prove the feasibility of this method of procedure, but as a rule they have proved unsatisfactory. The operation has been performed 65 times on man. The recorded mortality has been 18, or a little less than 30 per cent. Six of these died from the shock and severity of the operation for the condition calling for the grafting. In at

least 7 cases death resulted in from 5 days to 2 years after operation, from infection of the kidney, peritonitis or other untoward result of the rectal implantation. In 5 cases the cause of death was obscure and in 2 cases the result is not published. When one considers that of deaths from all causes, 40 per cent. are from subsequent infection, the suspicion that some of the reported successful cases may also later succumb to infection, seems reasonable. This high rate of mortality must necessarily cause anxiety as to the justifiability of the operation and were it not for the excellent work of Maydl, followed so successfully by a number of other surgeons, one might look on the subject with almost condemnation. Only 8 deaths have followed the operations done by his method, a mortality rate of but 21 per cent., and the danger of peritonitis and subsequent kidney infection has been very greatly reduced. There are 5 methods of forming an anastomosis between the ureter and the rectum: (1) by the formation of a fistula between them; (2) by the axial implantation of the ureteral stump into the bowel and its fixation there by either the Lembert or the double-row suture; (3) implantation of both ureters with a piece of the bladder, as by Maydl, Pozzi and others; (4) implantation of both ureters with a small amount of the bladder mucous membrane; (5) by means of apparatus such as that of Calot and Boari. Of these the Maydl operation has given the best results. The skin implantation of the ureter has been advised by some surgeons, but it is believed that the danger of infection is very great and that nephrectomy ultimately would be required. The operation has been done 10 times with 3 deaths. One subsequently required nephrectomy, in 4 the result is not given and in 2 cases ascending infection occurred. These statistics clearly indicate that bowel implantation is a much more favorable operation. The ureter has been implanted into the vagina but 3 times, all of which were successful. But little can be said in favor of this method, for notwithstanding that the three cases in which it has been done were successful, yet it seems to be grafting a perpetual infirmity upon an individual. The ureters have been grafted in the urethra in 5 cases, in 4 of which ectopia vesicæ was the condition, the relief from which was sought. Three of these recovered and two died. This operation has a very limited field and it will never replace the method of bowel implantation.

Migrated Ovarian Tumors.—Dr. George M. Edebohl of New York read this paper by title.

Best Method of Extirpating Fibroid Uteri.—Dr. Howard A. Kelly of Baltimore then read this paper. After describing the various ordinary methods of operating that he had used, he said that he had now adopted a new method of his own. The technic for ordinary cases is to make a vaginal incision, then ligate the ovarian vessels on one side and also pass a ligature around the round ligament. The vessels and the ligament are then divided. Then open the top of the

broad ligament and push down the bladder with the broad ligament and so expose the uterine vessels of that side, which are then ligated. The cervix is then divided, exposing the uterine vessels of the opposite side. The uterus, free from the cervix, is then pulled upward and outward exposing successively the round ligament and the remaining ovarian vessels which are then ligated. The cervical wound is closed and the peritoneum of the bladder drawn downward over the wounded area. In exceptionally difficult cases, due to the low origin of a low fibroid choking up the pelvis, and where the ovarian and uterine vessel are so spread out on the upper cervical surface that it is impossible to tie them in mass, a quicker and safer method is to grasp both cornua with strong forceps and then split the uterus and tumors down to the vaginal cervix. The cervix is then divided to the right and to the left, exposing the uterine vessels which are clamped. The uterus freed from the cervix is then pulled out first to one side and then to the other and the ovarian vessels controlled. In this way there is very much less danger from hemorrhage. Precisely the same methods of treatment are applicable to inflammatory cases. After removing the uterus in this way the adherent tubes and ovaries can be dissected out very easily.

Kelly's Method of Removing Fibroids of the Uterus.—Dr. A. Lapthorn Smith of Montreal read the next paper and spoke of the very good results which he had had by operating in the method just described by Dr. Kelly.

Intra-Abdominal Amputation of Uterus.—A modification of hysterectomy, by Dr. F. H. Davenport of Boston, was the next paper on the program. He said that the indications for hysterectomy are well established and its mortality has been reduced to such limits that it ranks with other operations as a thoroughly safe method of procedure. Interest is now centered in the technic. He believes in regard to the relative advantages of the vaginal and abdominal routes that one should be governed by the conditions of each particular case. If the patient be single or near the menopause, the case one of a small or medium-sized non-adherent fibroid and the patient object to the scar that would follow an abdominal hysterectomy, do the operation by the vaginal route. This has the advantage of being quicker, is followed by less shock and the period of convalescence is much more comfortable. On the other hand in a young married woman always perform an abdominal hysterectomy so as to retain the vagina in such position that it will be functionally serviceable. A shortened vagina with a contracted vault is not a desirable condition under these circumstances. There is no danger of the abdominal scar being stretched by a subsequent pregnancy and hernia, while a possible sequela in these days of careful suturing a very remote one. It is generally best to employ the abdominal route when removing the uterus for chronic inflammatory conditions for the reason that there is usually concomitant dis-

case of the appendages and the abdominal route gives full opportunity to see the exact condition of all the pelvic organs and so what is necessary may be done under the control of the eye. The technic of hysterectomy may be much simplified for in many cases the body of the uterus alone need be removed, leaving the cervix and perhaps the lowest segment of the uterine body. Where the uterus is chronically inflamed, which keeps up salpingitis and perhaps peritonitis, it is only necessary to obliterate the uterine canal and remove the inflamed tubes to effect a cure. The lower part of the uterus and the cervix will drain freely into the vagina and ultimately undergo atrophy. The essential features in which his method differs from the operation as usually performed is that the uterine arteries are not ligated or, in fact, even disturbed. By whatever method these are treated, whether by tying the arteries or ligating them by including the whole thickness of the broad ligament near the uterus, it is more or less a difficult procedure. The first method involves the opening of the subperitoneal space, thereby increasing the chances of septic infection, and it is good surgery to limit the chances of this as much as possible. The technic of his method is as follows: The broad ligament of each side is seized by a long clamp running from the free space between the ovaries and tubes and the pelvic wall and ending close to the uterine wall at a point a little above the level of the internal os. A second clamp is carried down each side parallel to the first clamp. The clamps having been firmly applied there can be no bleeding. A needle armed with a fine silk ligature is then passed through the angle of the broad ligament between the ends of the clamps and is securely fastened. With a scalpel the uterine tissues are then divided at a level with this suture and in such a way that the anterior and posterior incisions slope downward and meet in the center. This is done from one side of the uterus to the other, a little at a time and the bleeding, which is usually slight, is controlled by the continuous suture which follows the incision. The needle threaded with the silk which has been tied at the angle is introduced into the anterior surface of the uterus just below the free edge, then carried through the tissues and finally brought out at the angle of the wound. It is then reintroduced into the posterior wall and emerges on the posterior surface of the uterus at a point corresponding to its entrance. This is drawn tightly and when enough free space has been gained by the use of the knife another suture is taken. This is continued until the body of the uterus is completely separated and the other side is reached. Then a final stitch is securely tied at the angle of the broad ligament between the clamps. By this method all bleeding is absolutely prevented. It is not necessary to strip the peritoneum off the uterus and the wedge-shaped removal of the uterine body permits the ready and close apposition of the peritoneum. Any little bleeding points on the line of the continuous suture can be con-

trolled later by separate sutures. When the clamps which control the outer segment of the broad ligaments are removed the ovarian arteries may be seized and ligated. There is usually no bleeding from the rest of the broad ligament, but any suspicious points may be tied. This operation has many distinct advantages and it is surprising how often it may be substituted for the more radical one in which the uterine arteries are ligated. Among its advantages are the following: It takes a shorter time to perform; there is usually little loss of blood; it does not open the layers of the broad ligament, and convalescence, as a rule, is short and very free from disturbance.

Dr. Pryor of New York opened the discussion on the three preceding papers and said that when there are several fibroid nodules in the uterus his method is to first tie the ovarian vessels and then split the tumors. Traction forceps to hold the flaps apart are then applied and the tumors removed. The operation is completed by tying the uterine vessels.

Dr. Gordon of Portland, Me., said that for many years he had been employing the continuous suture, carrying it all the way down until the stump was completely covered. In his experience chromicized catgut is a very bad material for suturing as in many cases it is practically never absorbed and in time acts as a foreign body. Ordinary catgut has proven itself to be the best material for suture that he has ever tried and he has never had a case in which silk sutures were indicated, or a stitch abscess occurred. He employs a through-and-through buried silkworm-gut suture which are left in place for from two to three weeks. The ideal method of closing a wound consists in using for sutures only such materials as are easily absorbed.

Dr. Mann of Buffalo said that he believed the methods mentioned by Dr. Kelly and Dr. Pryor are not always the easiest. In those cases where the tumor is held down in the pelvis by the broad ligament, on cutting that ligament and the infundibuliform-pelvic ligament the tumor will come up. Then tie the uterine and ovarian vessels. This is an easier method than that advocated by Dr. Pryor, for the reason that, although the tumor can be removed in a few minutes by his method, the operation is not finished and requires a long time for its completion. It is generally better to tie off the broad ligament before removing the tumor as thereby hemostasis is more complete. The cervix should be dilated and a piece of gauze passed through it, as this will give very much better drainage than if the cervix be removed.

Dr. Baldy of Philadelphia said that he had had a case in which the tumor extended over the bladder. He opened the cul-de-sac posteriorly and performed the same operation as Doyen claimed for his own. Bad cases like these are rare, and such an operation as Dr. Kelly advises is only of use in an emergency. He considers Dr. Pryor's method to be a very dangerous one and not a good routine method of practice. It is an extremely

difficult one for any but an expert, and so should be avoided by beginners. He had seen one operator in doing it tie both ureters and another one tie one ureter. However, it may prove to be a serviceable method of procedure in those cases in which the real character of the tissues are disguised by inflammation.

Dr. Reynolds of Boston said that he had adopted the method of tying the ovarian arteries on each side, then drawing the uterus up strongly, and putting on a clamp on each side one-quarter of an inch above the junction of the uterus and the bladder. He then cut just above the tip of the forceps on each side. A suture was then entered from before backward through the uterine wall and brought out just below the incision on the broad ligament. The same is done on the other side, and a wedge-shaped cut is made in the uterus extending down to the internal os. A suture is introduced to approximate the cut edges and the operation completed by turning the stump.

Dr. Johnstone of Cincinnati said that the personal equation is a very large factor in all operations, and that he believes that Dr. Kelly's troubles are all of his own making. He had had a similar case and after making a vaginal incision tied all of the vessels before doing anything else. The operation was easily completed and there was no bleeding to complicate it. The priority of uterine ligation should be credited to Dr. Polk.

Dr. Harris of Paterson said that the continuous incision is the easiest possible method of supravaginal hysterectomy, as it is not a difficult operation and it is well suited to all cases.

Dr. Kelly, in closing, said that the Guyon method is merely a series of surgical gymnastics, suitable only to very easy cases, as it can not possibly be performed in difficult ones. The bisecting method is especially good in bad cases, as there is no risk to the ureters if one is careful to push down the bladder. He does not believe it good practice to remove small fibroid uteri, and in dealing with those which are of such small size that a clamp can be used, he either performs myomectomy or else does not operate upon them at all.

The President's Address.—This was delivered by Dr. George J. Engelmann of Boston. After reviewing at length the history of the Society since its foundation and the progress made in gynecology and obstetrics during that period, he said that he would direct the attention of the Society to the subject of menstruation. This is always a period of danger, a period of highest susceptibility, more dangerous to the nervous organism than to the physical structures. It is in puberty and the formative period that this all-pervading function which controls woman's entire being is readily moulded and controlled by surrounding conditions of all kinds. Puberty or the establishing of functional life is swayed by the most varied conditions; race and climate influence its advent, but equally, if not more so, is it controlled by social conditions and mental

status. It is most important to note the effect of mental activity. Many investigators have shown that the wealthy and the city-born are more precocious than their poorer or their country-bred sisters, but my own investigations more especially indicate the influence of mental stimulus. Thus, out of 2315 patients who came under my observation in St. Louis dispensaries, the average age at which menstruation commenced was 14.24 years, while Dr. Chadwick of Boston has found much the same, for in his 2500 cases the age was 14.3 years. In 697 cases from a consulting practice throughout the Southwestern States, country-bred women, the average age was 14.3 years. The average in 800 cases among Boston's highest class working-girls was 14 years. Among the high and normal school girls, the 750 of whom statistics were collected gave the average of 13.8 years. In 1200 college girls the average was 13.5 years. Neither birthplace nor parentage influences the development of the girl and the appearance of puberty, as do the surroundings of childhood and early youth, which give a variation of one year, as noted in the 5000 cases which have been under observation. The author emphasized the susceptibility of the function to mental influence and likewise the controlling influence of the function upon the anatomical, physiological and pathological status of the growing girl.

(To be Continued.)

REVIEWS.

A Pocket Medical Dictionary. Fourth Edition, Revised and Enlarged. By GEORGE M. GOULD, A.M., M.D. Philadelphia: P. Blakiston's Son & Company.

THIS is a convenient little book to have at one's elbow. The text is clear, the pronunciation of each word is given, and the definition is concise and comprehensive. In this new edition a large number of additional eponymic clinical terms have been introduced, the dose-table has been enlarged to include doses and drugs recently introduced, and a number of inaccuracies in former editions have been corrected. It has flexible covers and gilt edges.

Progressive Medicine, March, 1900. Quarterly Digest of Advances in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE and CHARLES ADAMS HOLDER. Volume I, March, 1900. Lea Brothers & Co.: Philadelphia and New York.

THE first volume for the second year of this periodical, containing, therefore, the first repetition of the review of the subjects treated, shows that the original purpose of the editor and contributors is being kept thoroughly in view. *Progressive Medicine* supplies a very personal authoritative discussion of the latest subjects of interest in medicine, surgery and the specialties.

Dr. J. Chalmers Da Costa's review of the various incisions suggested for the radical operation for cancer of the breast is illustrated in a manner to make this subject extremely clear. The success of Halsted's method of operation and the number of adherents it has gained among prominent surgeons all over the world are well brought out. The place of Beetsen's method, the removal of the ovaries and the administration of thyroid extract for inoperable carcinoma of the breast, is made very clear. That some good is accomplished by this method there is no reason to doubt. The ultimate effect of the treatment is, however, as yet entirely unknown.

Acute articular rheumatism is very properly included among the infectious diseases. Dr. Frederick Packard makes a plea for the more careful use of the word rheumatism. Too many vague painful conditions are grouped under this term. The use of such expressions as gonorrheal rheumatism, scarlatinal rheumatism, pyemic rheumatism, is deprecated because they give a false idea of the nature of the process at work. The conclusion is suggested that the near future will demonstrate acute articular rheumatism to be really a modified pyemia. It is not, however, so much the actual presence of micro-organisms in the blood which causes the manifestations of rheumatism as toxic principles of a chemical nature whose presence sets up symptoms of the disease. The humoral theory that attributes acute articular rheumatism to the excessive formation of lactic acid in the blood is set down as utterly unconfirmed. It is not impossible, however, that a certain amount of this substance is produced during the course of the rheumatism and causes some of the arthritic symptoms. But it is a secondary not a primary factor in the rheumatic condition.

Dr. Blackader has a very timely review of the affections of the alimentary tract in children and of the modification of milk for infant-feeding during the trying summer months. Variations in the amount of the different constituents of cow's milk during the uncertain feeding of the grazing period—the spring and summer—are especially dwelt on. The question of the addition of cereals to milk is treated from the standpoint of the new interest that has been awakened in this subject during recent years. There seems now no reason to doubt that the addition of cereals, instead of being harmful, is always beneficial. Nitrogenous elimination in the infant is always decreased by the administration of a certain amount of carbohydrates. Heubner's investigations emphasize the importance of non-nitrogenous food because it favors growth by protecting the albumens from useless decomposition. This is a new idea and one which shows that pediatricists now recognize that the problem of infant-feeding is no longer the simple chemical question of digestibility but that there are a number of important biological factors that enter into it.

Other things in the volume might be mentioned, such as Dr. Randolph's review of mastoid

complications and sinus thrombosis, Dr. Turner's discussion of the use of new therapeutic agents in the nose and throat, and Dr. Haktoen's review of the theory of antitoxin and of the recently-discovered pathogenic micro-organisms; but amidst so much that is good the reviewer is limited in selection.

The Year-Book of the Nose, Throat and Ear. Nose and Throat edited by G. P. HEAD, Professor of Laryngology and Rhinology, Post-Graduate Medical School of Chicago; The Ear Edited by A. H. ANDREWS, Professor of Otolaryngology, Post-Graduate Medical School of Chicago. Chicago Medical Book Co., 1900. Pp. 274.

THE editors have in this work abstracted the special literature of the past year and have grouped it under appropriate anatomical and pathological headings. Thus, with the aid of the fairly complete index a large amount of useful matter is placed within easy reach of the general practitioner. The foreign journals have been freely consulted, and special articles have been devoted to some of the newer remedies, such as suprarenal extract, heroin, and orthoform. One finds here the different methods in vogue among specialists the world over. The remedies for tuberculous laryngitis, for instance, include scarification, curetting, electrocautery, submucous injections of creosote, intratracheal injections, lactic acid, formic acid, formaldehyd, orthoform, iodoform, para- and ortho-monochlorophenol, guaiacol, ichthyol, absolute alcohol, lanoline containing 3 per cent. naphthalin and oxidized tubercle toxins. In the body of the work a fair number of useful prescriptions have been included. Although the editors are themselves specialists they rarely express opinions of their own, but leave the reader to his own summing up of the literature, and his own choice of remedies.

THERAPEUTIC HINTS.

Hot Local Baths for Infected Wounds.—*Platonov* uses this treatment with excellent results; the secretion of pus diminishes, the healing process is quickened, and the immediate effect is soothing. He finds it best to give the baths just before renewing the dressing. The temperature should be from 90° to 104° F.

Varicose ulcers also improve under the bath treatment; the sloughs are thrown off more rapidly, and the secretion loses its fetidity by which it is often characterized. In case of infected wounds cicatrization is hastened; this is, however, not true of varicose ulcers.

For Chancreoid.—*Frolov* highly recommends the biniodosalicylate of soda in the form of a 2 per cent. ointment for recent cases, or 10 to 15 per cent. in neglected cases. It acts as a cautery, gradually destroying the diseased tissue at the periphery of the sore, although it is almost or even entirely painless, and possesses the added advantage of being odorless.